

4282

CERTIFICATE OF DEATH

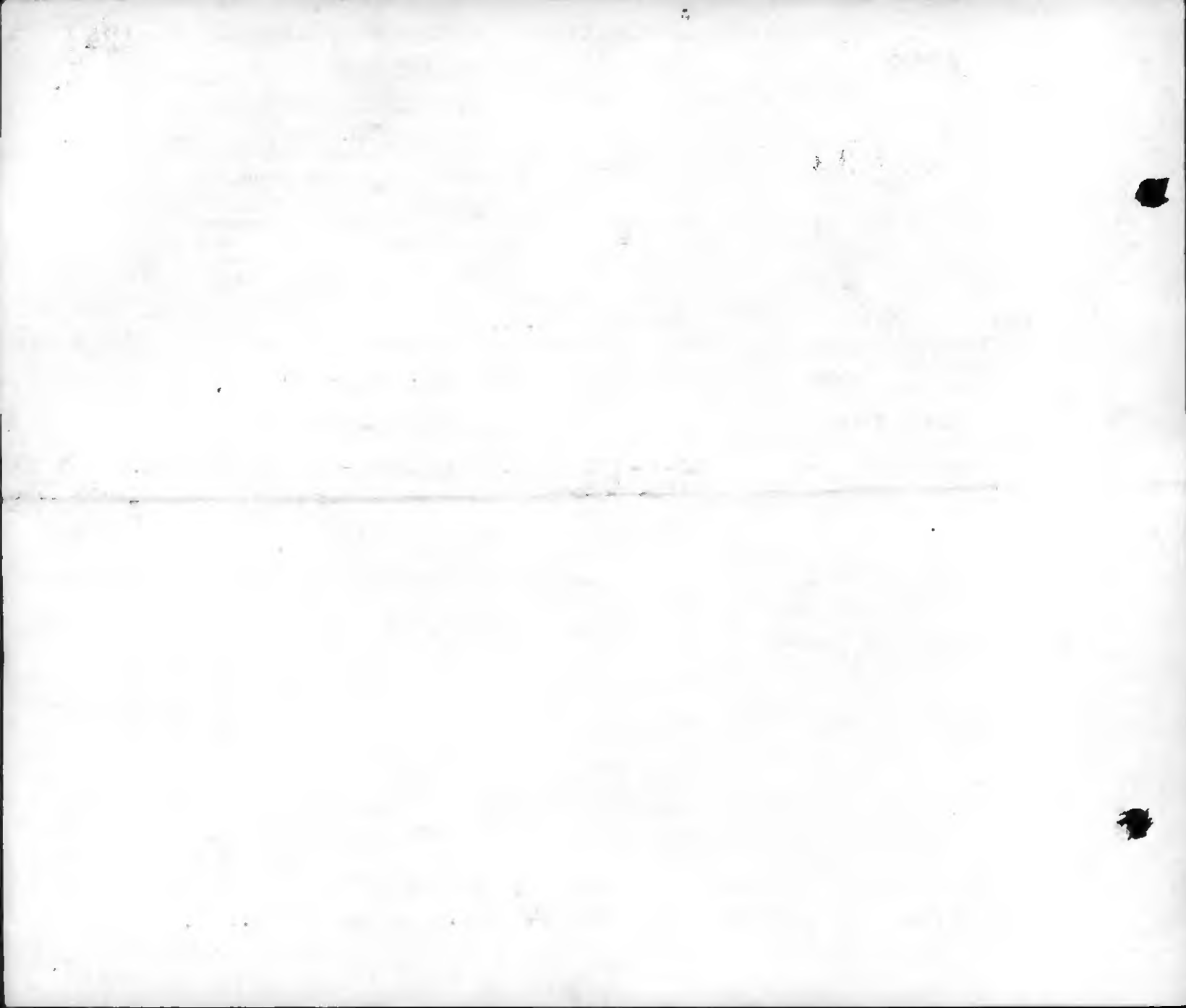
Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY A. A.		MARYLAND		STATE Md.		COUNTY A. A.	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Riviera Beach				TOWN Riviera Beach		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Kenwood and Greenway				STREET ADDRESS (If rural give location) Kenwood & Greenway			
3. NAME OF DECEASED: (First) HENRY (Middle) (Last) ARTES				4. DATE OF DEATH: (Month) May (Day) 24 (Year) 19 55			
5. SEX: male		5. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married		8. DATE OF BIRTH: Aug. 1, 1868	
				9. AGE last birthday: 86 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Cutter				10b. KIND OF BUSINESS OR INDUSTRY: Shoes		11. BIRTHPLACE (State or foreign country): Wash. D. C.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME: Henry Artes				14. MOTHER'S MAIDEN NAME: Johanna Seebae			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 3 no --				16. SOCIAL SECURITY No.: 212-14-0054 A			
				17. INFORMANT & ADDRESS: Mr. Henry Artes - 5206 Catalpha Rd.			

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
331X Immediate cause (a) Cerebral hemorrhage DUE TO				1 month	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) generalized arteriosclerosis DUE TO				Not known	
(c) left hemiplegia				1 month	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION: 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Mar. 18, 1955, to May 24, 1955, that I last saw the deceased alive on May 24, 1955, and that death occurred at 11:00 A.M., from the causes and on the date stated above.					
SIGNATURE R. M. McLaughlin M.D.		ADDRESS Pasadena, Md.		DATE SIGNED May 24, 1955	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 5/27/55		NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	
LOCATION (City, town, or county) Balto. Md.					
DATE REC'D BY LOCAL REGISTRAR 5-25-55		REGISTRAR'S SIGNATURE R. M. McLaughlin		24. FUNERAL DIRECTOR Dr. J. T. Tschoner & Sons - Balto 17 Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04248

4257

CERTIFICATE OF DEATH

Reg. Dist. No. 21

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A. Co.</u>		MARYLAND		STATE <u>Mo.</u>		COUNTY <u>A.A. Co.</u>	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ANNAPOLIS</u>				TOWN <u>ANNAPOLIS</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>518 BURUSIDE ST.</u>				STREET ADDRESS (If rural give location) <u>518 BURUSIDE ST.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>VERONICA</u> (Middle) <u>BENDA</u> (Last)				(Month) <u>5</u> (Day) <u>9</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>5/24/1887</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>J.J. BENDA JR. #2</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
157X IMMEDIATE CAUSE (A) <u>carcinoma of pancreas with gen. metastasis</u> 5 mos.							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>3/25/55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Ca pancreas c metastasis</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/4/55</u> , 19....., to <u>5/9/55</u> , 19....., that I last saw the deceased alive on <u>5/8/55</u> , 19....., and that death occurred at <u>10:15 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>S. Borman</u>		M.D. <u>Annapolis, Md.</u>		ADDRESS (Street, city, town, state)		DATE SIGNED <u>5/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>5/12/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		LOCATION (City, town, or county) (State) <u>Annapolis Mo.</u>	
24. REC'D BY REGISTRAR <u>May 11, 1955</u>		REGISTRAR'S SIGNATURE <u>J. J. Benda</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis, Mo.</u>	

11228

CERTIFICATE OF DEATH

1955

DATE OF DEATH

PLACE OF DEATH

DECEASED

VENUE

HOME

UNKNOWN

BUREAU V. S.

MAY 13 1955

RECEIVED

4258

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Annapolis</u> TOWN <u>Annapolis</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>23 Francis St.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>AA</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> TOWN <u>Annapolis</u> STREET ADDRESS (If rural, give location) <u>23 Francis St.</u>	
3. NAME OF DECEASED (Type or Print) <u>George</u> (First) <u>E</u> (Middle) <u>Benedict</u> (Last)		4. DATE OF DEATH <u>5-28-55</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>Aug. 3-1898</u> (Month) (Day) (Year)
9. AGE last birthday <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Marine</u>	
11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George H. Benedict</u>		14. MOTHER'S MAIDEN NAME <u>Eva Wolfe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>II</u>		16. SOCIAL SECURITY No. <u>212-28-1619</u>	
17. INFORMANT AND ADDRESS <u>Louisa V. Benedict</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>420.1 Coronary Disease</u> Immediate cause		
(b) <u>Antecedent cause(s)</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) <u>2</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>	
SIGNATURE <u>Gen. Ladd</u>	DATE SIGNED <u>5/28/55</u>

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>June 1, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>National Cemetery</u>		LOCATION (City, town, or county) <u>Annapolis Md.</u>	
DATE REC'D BY LOCAL REG. <u>June 1, 1955</u>		REGISTRAR'S SIGNATURE <u>J. J. O'Donoghue</u>		24. FUNERAL DIRECTOR <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JUN 2 1955

RECEIVED

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4259

CERTIFICATE OF DEATH

04250

21

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		<u>6 days</u>		TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>USN Hospital</u>				STREET ADDRESS (If rural give location) <u>1519 Light Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Charles Andrew BOHLE</u>				<u>May 1 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>Cau</u>	<u>M</u>	<u>3-29-94</u>	<u>61</u> yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>USN</u>		<u>Retired</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Conrad BOHLE</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH WIEGAND</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, ap, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes</u> <u>2-42</u>						<u>U.S.N H. Records</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>3 hrs</u>			
IMMEDIATE CAUSE (A) <u>Congestive Heart Failure # 434.1</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease # 330</u>				<u>Indef.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-24-</u> <u>19 55</u> , to <u>5-1-</u> <u>19 55</u> , that I last saw the deceased alive on <u>5-1-</u> <u>19 55</u> , and that death occurred at <u>1145a.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>G. M. Hinkadi</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>G. M. Hinkadi LCDR MC USNR</u>				<u>M.D. U.S. Naval Hospital, Annapolis, Md.</u>		<u>2 May 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5-4-55</u>		<u>BALTIMORE NATIONAL</u>		<u>5501 FREDERICK AV. BALTO. MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>5/4/55</u>		<u>Wm. J. French</u>		<u>Charles S. Zeller</u>		<u>901 S. CONKLING ST. BALTO., MD.</u>	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Report		Time of Report		Place of Report	

BUREAU V. 2

MAY 4 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04251

4283

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Glenburnie</u>				TOWN <u>Glenburnie</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>105 Drum Point Ave., S. E.</u>				STREET ADDRESS (If rural give location) <u>105 Drum Point Ave.</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>ANNE</u> (Middle)		(Last) <u>BRAYSHAW</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>21</u> (Year) <u>1955</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 22, 1862</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>never worked</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Brayshaw</u>				14. MOTHER'S MAIDEN NAME <u>Julia Lacey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Glenburnie, Md.</u> <u>Mr. Thomas Brayshaw-105 Drum Point Ave.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>422.2</u> IMMEDIATE CAUSE (A) <u>Infantion</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAY 19, 1954</u> , to <u>MAY 19, 1955</u> , that I last saw the deceased alive on <u>5-17</u> , 19 <u>55</u> , and that death occurred at <u>4:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>CR Mac Donald M.D.</u> M.D.				ADDRESS (Street, city, town, state) <u>Eden, Md.</u>		DATE SIGNED <u>5-21-55</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>Louis J. DeAlba</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Vickner & Sons</u>		ADDRESS <u>Ba...</u>	
DATE <u>May 23, 1955</u>							

CERTIFICATE OF DEATH

4/73

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

RECEIVED

BUREAU V. 1

MAY 24 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4284 CERTIFICATE OF DEATH

04252

Reg. Dist. No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY 17 Cherry Lane		MARYLAND		STATE Md		COUNTY A.A. Co	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY OR (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
X TOWN AA. County Cedar Hill		Life		TOWN Cedar Hill Md		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 17 Cherry Lane				STREET ADDRESS (If rural give location) 17 Cherry Lane			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
Bertha Irine Brooks				DATE OF DEATH: 5 9 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
F	C	Widowed	Nov-23-1882	72 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Housewife				Home		AA. County U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John Watkins				Laura Armstead			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						Sarah L Dyer 605 Richie Myway	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
171X IMMEDIATE CAUSE (A) Generalized Carcinomatosis							6 m.o.
ANTECEDENT CAUSE (B) Carcinoma of Cervix							1 year
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Myocarditis							3 yrs.
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
						INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
				M.			
22. I hereby certify that I attended the deceased from 2-2, 1948, to 5-9, 1955, that I last saw the deceased on 5-9, 1955, and that death occurred at 4:45 PM, from the causes and on the date stated above.							
SIGNATURE P. J. Grimaldi				ADDRESS M.D. 4609 Gov. Ritchie Hwy		DATE SIGNED 5-12-55	
23. BURIAL, CREMATION, OR REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		5-12-55		Mt Calvary Cem		Brooklyn Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
5-12-55		E. W. Wilson		E. W. Wilson		1000 Kenting Ave	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

4260

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ANNAPOLIS</u>				TOWN <u>ANNAPOLIS</u>		10	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>17 CALVERT ST</u>				<u>17 CALVERT ST</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>RICHARD WARDELL BROWN</u>				<u>5</u> <u>14</u> 19 <u>55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, or SEPARATED	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>Colored</u>	<u>Widowed</u>	<u>6-27-1881</u>	<u>73</u> yrs	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
<u>RE U.S. NAVAL ACADEMY</u>				<u>MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>RICHARD WARDELL BROWN</u>				<u>JANE A. DAYAGE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes</u> <u>SPANISH AMER</u>						<u>SARAH GREEN 108 SOUTH ST ANNAPOLIS</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
7824 IMMEDIATE CAUSE (A)				<u>Cardiac Thrombosis</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
<u>0</u>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-11-55</u> , to <u>5-14-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-12-55</u> , 19 <u>55</u> , and that death occurred at <u>10:25 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Ans. T. Allen</u>				ADDRESS (Street, city, town, state) <u>10 Conwell St</u>		DATE SIGNED <u>5-16-55</u>	
M.D. <u>Ans. T. Allen</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5-17-55</u>		<u>Brewer Hill</u>		<u>ANNAPOLIS, Md</u>	
24. REG'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>June 7, 1955</u>		<u>Wm J. Funch</u>		<u>William Reesett</u>		<u>108 W. WASH. ST ANNAPOLIS, Md</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

S A 111

ON 7 1955

111

4285

CERTIFICATE OF DEATH

04254

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN Glen Burnie

LENGTH OF STAY
(In this place)

1 year

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

107 Main Ave SW

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md.

COUNTY AA

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Glen Burnie X

STREET ADDRESS (If rural give location)

107 Main Ave SW

3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

EDNA HELEN BRUCKMAN

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

5

6

55

5. SEX

F

6. COLOR OR
RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

Married

8. DATE OF BIRTH

August 7, 1896

9. AGE last birthday

58

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Housewife

10b. KIND OF BUSINESS
OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Altoona, Pa.

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME

John Lamca

14. MOTHER'S MAIDEN NAME

Sarah Matthews

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

213 - 20 - 5425

17. INFORMANT & ADDRESS

John Bruckman, 107 Main Ave SW, Glen Burnie

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174 X IMMEDIATE CAUSE (A)

(A)

Carcinomatosis metastatic

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO

(B)

Carcinoma uterus

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.INTERVAL BETWEEN
ONSET AND DEATH

3 1/2

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21a. INJURY OCCURRED
While ☐ Not while ☐
at work ☐ at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 19 54, to MAY 19 55, that I last saw the deceased
alive on 5-3 19 55, and that death occurred at 7:30 p.m. from the causes and on the date stated above.

SIGNATURE

C. McDonald

M.D.

ADDRESS (Street, city, town, state)

Elsen Burnie Md

DATE SIGNED

5-6-55

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

5/10/55

NAME OF CEMETERY OR CREMATORY

Meadowridge Cemetery

LOCATION (City, town, or county)

Elkridge, Howard Co. Md.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

L. J. Delba

25. FUNERAL DIRECTOR'S SIGNATURE

James J. Hurlley
Hopping and Kirkley Funeral Home
Glen Burnie, Md.

ADDRESS

DATE

5/9/55

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

MAY 10 1957

RECEIVED
MAY 10 1957

1

INSTRUCTIONS

I

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04255

4286

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>AA</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Shodyside</u>		<u>Life</u>		TOWN <u>Shodyside</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Leonard</u> (Middle) <u>Hartman</u> (Last) <u>Bussey</u>				(Month) <u>5</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug. 19, 1904</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AA County</u>		11. BIRTHPLACE (State or foreign country) <u>Churchton Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Harris Bussey</u>				14. MOTHER'S MAIDEN NAME <u>Lucenia Franklin Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>222 210</u>		17. INFORMANT & ADDRESS			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
163X IMMEDIATE CAUSE (A) <u>Carcinoma lung</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Sept 21/54</u>		19b. MAJOR FINDINGS OF OPERATION <u>Fibroid core, normal</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 3, 1955</u> , to <u>May 22, 1955</u> , that I last saw the deceased alive on <u>May 19, 1955</u> , and that death occurred at <u>1:45 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Smith H. Wilson</u>		M.D.		ADDRESS (Street, city, town, state) <u>Esthonia, Md.</u>		DATE SIGNED <u>5-24-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 25/55</u>		NAME OF CEMETERY OR CREMATORY <u>Zion</u>		LOCATION (City, town, or county) (State) <u>Galesville Md.</u>	
24. REC'D BY REGISTRAR <u>May-25-55</u>		REGISTRAR'S SIGNATURE <u>J. B. Dent</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u> ADDRESS <u>Galesville Md.</u>			

U. S. GOVERNMENT

MAY 24 1900



4287

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>A.A.</u>	
CITY (if outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (if outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>EDGEWATER</u>				STREET ADDRESS		(if rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>WILLIAM</u> (Middle) <u>A.</u> (Last) <u>CADLE</u>				(Month) <u>5</u> (Day) <u>22</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>1-22-1876</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>WATERMAN</u>				<u>COYSTER CRABS</u>		<u>WASHINGTON D.C.</u>	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
<u>WILLIAM CADLE</u>				<u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS	
						<u>SARAH C. CADLE</u> (2)	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
151X IMMEDIATE CAUSE (A) <u>Carcinoma of Stomach</u>				ONSET AND DEATH <u>6 months</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>11</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 19, 1955</u> , to <u>5-22, 1955</u> , that I last saw the deceased alive on <u>5-21, 1955</u> , and that death occurred at <u>6:45 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>James H. Ina</u>				DATE SIGNED <u>Annapolis, Md - 22-55</u>			
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (city, town, or county) (State)	
<u>Burial</u>		<u>5-24-55</u>		<u>Edwards Chapel</u>		<u>Annapolis RFD Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 23, 1955</u>		<u>J. H. Ina</u>		<u>John M. Taylor Sons</u>		<u>Annapolis Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED

MAY 5 1961

RECEIVED

04257

4288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Glen Burnie</u>		LENGTH OF STAY (In this place) <u>5 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u>				STREET ADDRESS (If rural give location) <u>111 Georgia Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Annie</u> (Middle) <u>Elizabeth</u> (Last) <u>Canfield</u>				DATE OF DEATH <u>5</u> <u>17</u> 19 <u>55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>February 9, 1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Lightfoot</u>				14. MOTHER'S MAIDEN NAME <u>Adeline Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs Robert Campbell</u> <u>111 Georgia Ave</u> <u>Glen Burnie, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>4222</u> IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>5/19/55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>51</u> , to <u>May 16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 11</u> , 19 <u>55</u> , and that death occurred at <u>9 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		M.D. <u>[Signature]</u>		ADDRESS (Street, city, town, state) <u>Glen Burnie, Md.</u>		DATE SIGNED <u>5-17-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mt. Airy, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>May 18, 1955</u>		REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Kirkley</u> ADDRESS <u>Hopping & Kirkley, Glen Burnie, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

BRUNNEN

MAY 20 1955

W. G. W. V. 1955

1

04253

4261

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MD</u>		COUNTY <u>A.A.Co.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>ANNAPOLIS MD.</u>				OR TOWN <u>ANNAPOLIS MD.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A.A. GENERAL Hospt.</u>				STREET ADDRESS <u>CARVER Hall Hotel</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOSEPH</u> (Middle) <u>CIERI</u> (Last)				(Month) <u>5</u> (Day) <u>11</u> (Year) <u>19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3/9/1890</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel Barber</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>VINCENT CIERI</u>				14. MOTHER'S MAIDEN NAME <u>CHIARA Blandi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WWI</u>		17. INFORMANT & ADDRESS <u>MARY M.K. CIERI #2</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>				<u>5 min.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>E. Anginal Syndrome</u>				<u>6 yrs.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/18</u> , 19 <u>52</u> to <u>5/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/15</u> , 19 <u>55</u> , and that death occurred at <u>12:30 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Smith</u>				M.D. <u>Annapolis, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>5/16/55</u>		<u>5/16/55</u>		<u>Arlington National</u>		<u>Arlington Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 16, 1955</u>		<u>J. O. Daniel</u>		<u>John M. Taylor & Sons</u>		<u>Annapolis, Md.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be delivered for use as a burial transit permit.

VS AISC 1-55 10M



4262

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>C. D.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. D. General</u>		STREET ADDRESS <u>106 South St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Don</u> (First) <u>Pence</u> (Middle) <u>Coats</u> (Last)		4. DATE OF DEATH <u>5</u> (Month) <u>9</u> (Day) <u>1955</u> (Year)	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>3</u>		8. DATE OF BIRTH <u>3-14-55</u>	
9. AGE last birthday <u>1</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Howard L. Coats</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Tyler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Howard Coats in Long</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>491X</u> Immediate cause (a) <u>Traumatic asphyxia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not while work at work	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input checked="" type="checkbox"/> homicide <input checked="" type="checkbox"/> undetermined <input checked="" type="checkbox"/> SIGNATURE <u>E. W. Hall</u> (Degree or title) <u>MD</u> ADDRESS <u>Annapolis</u> DATE SIGNED <u>8/9/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
DATE REG'D BY LOCAL REG.		REGISTERED SIGNATURE	
FUNERAL DIRECTOR		ADDRESS	

04260

4263

CERTIFICATE OF DEATH

Reg. Dist. No. 21

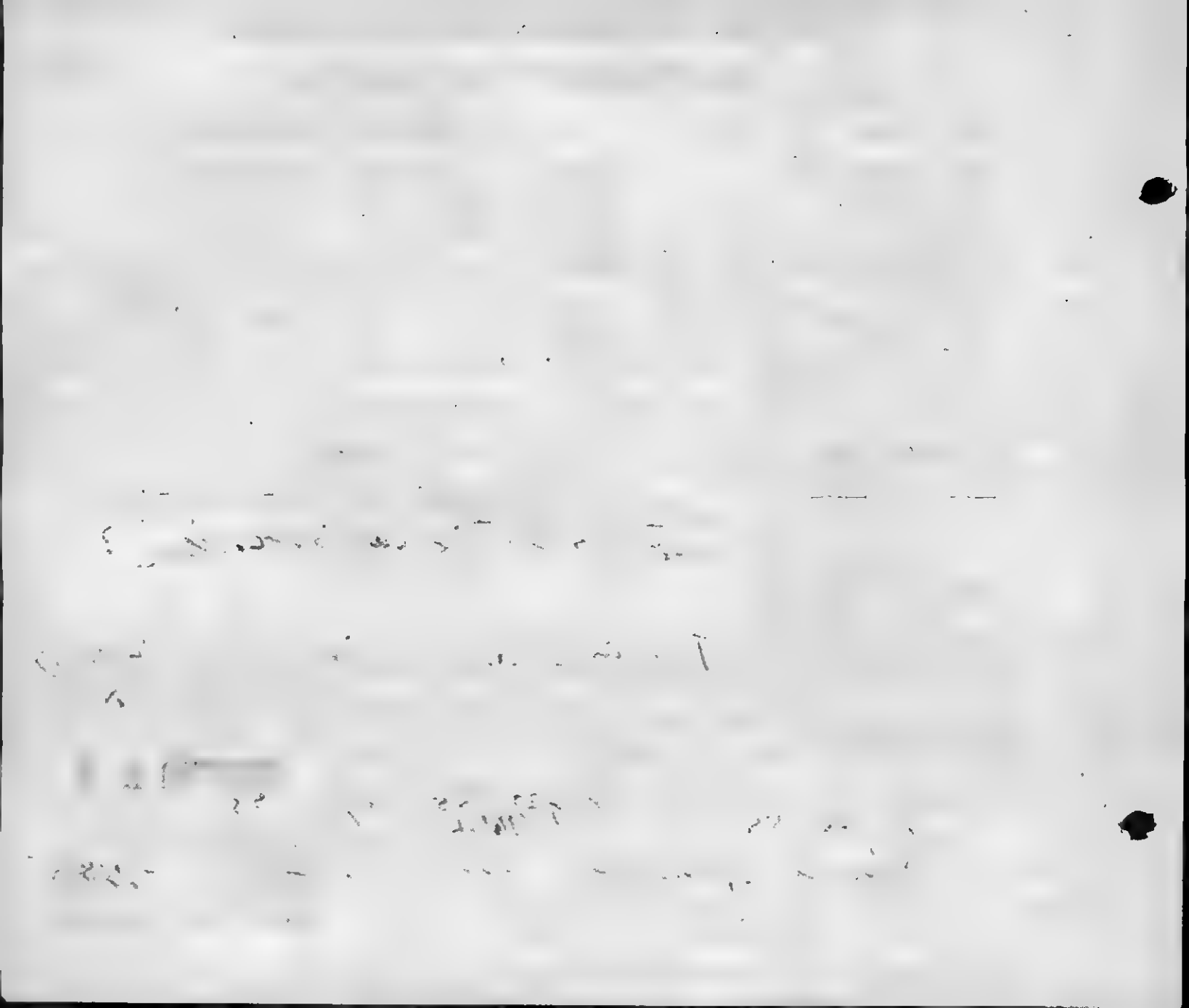
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mayo			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) ALICE E CUMMINGS				4. DATE OF DEATH May 28, 1955			
5. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed		8. DATE OF BIRTH Dec. 29, 1875	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home		9. AGE last birthday 79 Yrs.		11. BIRTHPLACE (State or foreign country) Mayo, Maryland	
13. FATHER'S NAME James Collison				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) none				14. MOTHER'S MAIDEN NAME Eugenia Purdy			
16. SOCIAL SECURITY NO. none				17. INFORMANT & ADDRESS Mrs Hilda E Morris-Daughter same as # 2			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Arteriosclerotic Cardio Vasc. Disease						?	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Terminal B. Pneumonia						2 days	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 27, 1955 to May 28, 1955 , that I last saw the deceased alive on May 28, 1955 , and that death occurred at 11:50 AM , from the causes and on the date stated above.							
SIGNATURE Mamie H. Lewis		M.D. Chimpanis Hall		ADDRESS (Street, city, town, state) Mayo, Maryland		DATE SIGNED 6/6/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF June 1, 1955		NAME OF CEMETERY OR CREMATORY Mayo Memorial Cemetery		LOCATION (City, town, or county) (State) Mayo, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS HOPPING FUNERAL HOME ANNAPOLIS, MD.	
DATE June 1, 1955							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4289

CERTIFICATE OF DEATH

04261

Reg. Dist. No. 28

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crownsville</u>		LENGTH OF STAY (in this place) <u>3 yrs. 9 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Unknown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>Unknown</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Abednego</u> (Middle) (Last) <u>Davis</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>5</u> <u>4</u> <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12/2/74</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Lloyd Davis</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
451X IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Known to us</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis-Multiple Myocardial Infarctions</u>				<u>1/5/54</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Aortic Aneurysm</u>				<u>Known to us since 7/24/51</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>General Paresis</u>				<u>Known to us since 7/21/51</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/27/</u> , 19 <u>51</u> , to <u>5/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/4</u> , 19 <u>55</u> , and that death occurred at <u>6:45a</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Stanley P. Sargant</u> M.D.				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>		DATE SIGNED <u>5/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 5, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Hall Plains Church Cemetery A. C. Co.</u>		LOCATION (City, town, or county) (State) <u>A. C. Co. Md.</u>	
24. REC'D BY REGISTRAR DATE <u>May 9, 1955</u>		REGISTRAR'S SIGNATURE <u>atherine M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel H. Sullivan</u>		ADDRESS <u>1011-4</u>	

STATE OF NEW YORK

IN SENATE

January 1, 1907

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4290

CERTIFICATE OF DEATH

04262

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Crownsville</u>		<u>2 1/2</u> years		TOWN <u>Baltimore</u>		<u>3V. 1-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital, Md.</u>				STREET ADDRESS (If rural give location) <u>2415 Terra Firma Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Wayne</u>		(Middle) <u>Tyrone</u>		(Last) <u>Davis</u>		(Month) <u>5</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR		
<u>Male</u>	<u>Negro</u>	<u>single</u>	<u>1938</u>	<u>17</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
<u>None</u>					<u>Maryland</u>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Edward Davis</u>				<u>Lillie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<u>no</u>					<u>Crownsville State Hospital, Md.</u>		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>351+</u>				<u>Cerebral hemorrhage or thrombosis - white</u>			
IMMEDIATE CAUSE (A)				<u>Congenital cerebral defect with spastic quadriplegia</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>3 days</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 13</u>, 19<u>52</u>, to <u>May 18</u>, 19<u>55</u>, that I last saw the deceased alive on <u>5/18</u>, 19<u>55</u>, and that death occurred at <u>7:50 PM</u>, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>[Signature]</u>				<u>5/19/55</u>			
ADDRESS (Street, city, town, state)				LOCATION (City, town, or county) (State)			
<u>Crownsville State Hospital, Md.</u>				<u>Baltimore city Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
		<u>5/23/55</u>		<u>mt Auburn</u>		<u>Baltimore city Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>May 19 1955</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>578 W. St. [Address]</u>	

BUTLER V. B.

MAY 23 1955

U.S. DIST. CT.
S.D.N.Y.

MARYLAND

STATE DEPARTMENT OF HEALTH

04263

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 12, FILE 181 5-20-55 et

1. PLACE OF DEATH COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>ANNE ARUNDEL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
TOWN <u>ANNAPOLIS</u>		TOWN <u>ANNAPOLIS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 DUKE OF GLOUCESTER</u>		STREET ADDRESS (If rural, give location) <u>82 DUKE OF GLOUCESTER</u>	
3. NAME OF DECEASED (Type or Print) <u>THOMAS ROSZELLE DAWSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 12 1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3-13-1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CONCESSIONER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONCESSIONER</u>	9. AGE last birthday <u>68</u> yrs. If under 1 year: Months Days If under 24 hrs: Hours Min.
13. FATHER'S NAME <u>GEORGE HENRY DAWSON</u>		11. BIRTHPLACE (State or foreign country) <u>CAMBRIDGE Md.</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY No. <u>W.W.I.</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
17. INFORMANT AND ADDRESS <u>MRS. THOMAS R. DAWSON</u>		(same address)	

5. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral hemorrhage

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

10 minutes

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
INJURY		m.			

22. I hereby certify that I attended the deceased from 3-31, 1955, to 5-12, 1955, that I last saw the deceasedalive on 5-6, 1955, and that death occurred at 8:30 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTERED SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

May 14, 1955J. J. O'DonnellJohn M. Taylor SonsAnnapolis Md.

BOMBAU

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

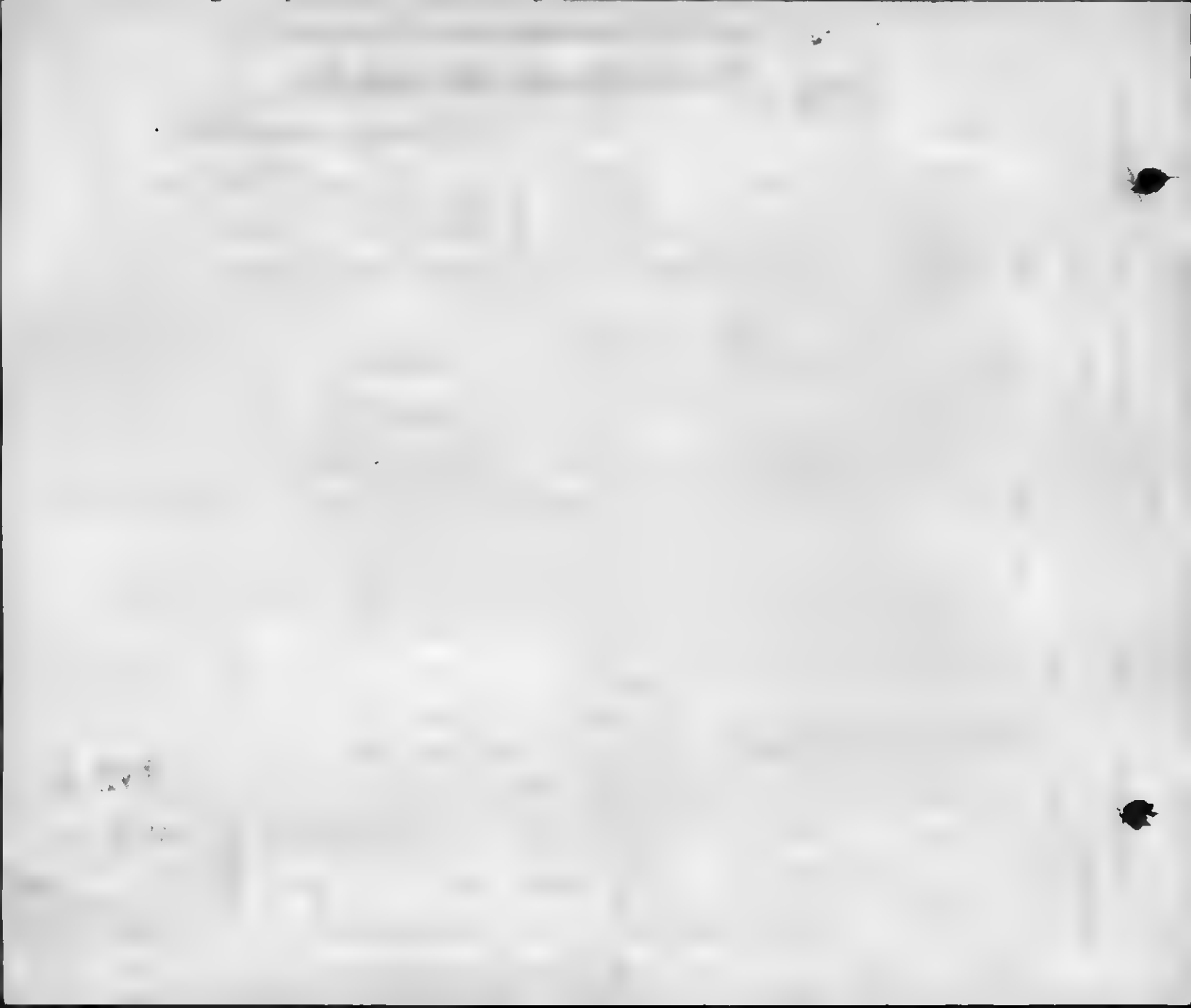
04264

CERTIFICATE OF DEATH

Item 12, Film 5-31-15 et

Reg. Dist. No. 31

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundell</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>aa</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Annapolis</i>		<i>1 day</i>		TOWN <i>Edgewater</i>		<i>X</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Ann Arundell General</i>				STREET ADDRESS (If rural give location) <i>County Home</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>FRANZ</i> (Middle) <i>DEIN</i> (Last)				(Month) <i>May</i> (Day) <i>10</i> (Year) <i>19 55</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>April 10 1870</i>	9. AGE last birthday <i>85</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seaman</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>unk</i>		16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT & ADDRESS <i>County Home Records, Edgewater Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>443 Hypertensive Cardiovascular Disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Fracture Femur Right</i>							
19a. DATE OF OPERATION <i>5/9/55</i>		19b. MAJOR FINDINGS OF OPERATION <i>Infection Fracture Femur</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) <i>County Home</i>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>5 9 55 P.M.</i>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>Fell at County Home</i>			
22. I hereby certify that I attended the deceased from <i>5-9-55</i> , 19 <i>55</i> , to <i>5-10</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>5-10</i> , 19 <i>55</i> , and that death occurred at <i>2 P.</i> M., from the causes and on the date stated above.							
SIGNATURE <i>E. F. Harbort</i>				ADDRESS (Street, city, town, state) <i>Annapolis, Maryland</i>		DATE SIGNED <i>5/17/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		DATE THEREOF <i>5/17/55</i>		NAME OF CEMETERY OR CREMATORY <i>County Home</i>		LOCATION (City, town, or county) (State) <i>Edgewater Md</i>	
24. REC'D BY REGISTRAR <i>U. Towel</i>		REGISTRAR'S SIGNATURE <i>Bernard Harbort</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Harbort</i>		ADDRESS <i>Edgewater Md</i>	
DATE <i>May 16, 1955</i>							



1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4266

CERTIFICATE OF DEATH

04265
Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MD.</u>		COUNTY <u>Anne Arundel</u>			
CITY OR TOWN <u>Annapolis MD.</u>		CITY OR TOWN <u>Shore Acres MDX</u>		CITY OR TOWN <u>Shore Acres MDX</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>		STREET ADDRESS <u>MAGOTHY AVE.</u>		STREET ADDRESS <u>MAGOTHY AVE.</u>			
3. NAME OF DECEASED (Type or Print) <u>Elizabeth Derschinger</u>				4. DATE OF DEATH <u>MAY 24 1955</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>Nov 10. 1876</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		9. AGE last birthday <u>78</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	
13. FATHER'S NAME <u>Charles Bohle</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Deist</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or not) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Husband Charles Derschinger Shore Acres Md</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocardial Insufficiency</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10 April 55</u> to <u>24 MAY 55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>24 MAY 55</u> , and that death occurred at <u>5:24 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Holm</u> M.D.				ADDRESS (Street, city, town, state) <u>Severna Park Md</u>		DATE SIGNED <u>24 MAY 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		LOCATION (City, town, or county) (State) <u>A.A. Co., Md.</u>	
24. REC'D BY REGISTRAR <u>May 26, 1955</u>		REGISTRAR'S SIGNATURE <u>Wm J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Fickner</u>		ADDRESS <u>Shore Acres Md</u>	

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4292 CERTIFICATE OF DEATH

04267

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Pennsylvania		COUNTY Allegheny	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Fort George G. Meade		6 Months		TOWN Pittsburgh			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
50 U. S. Army Hospital				3501 Old Orchard Circle			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) MARY (Middle) ALYCE (Last) FREDLAND Infant Girl Fredland				19 May 19 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Min.
Female	White	Single	19 May 1955			14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None				Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Alexander Fredland				Elizabeth Regina Schaldenbrand			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		Father 2012 N. Colvert St., Baltimore, Md.			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
712.5 IMMEDIATE CAUSE (A) ATZETASIS				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO Prematurity				14 hrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20		0					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 May 19 55, to 19 May 19 55, that I last saw the deceased alive on 19 May 19 55, and that death occurred at 8:50 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Herbert L. Tessedema M.D.				Fort Meade A.H.		19 May 55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial				Calvary Cemetery		Pittsburgh, Pennsylvania	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 20 May 1955		A. J. OCTOSH, CAPT. MSC		WILLIAM COOK		Baltimore, Maryland	

2055210322

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

RECEIVED

MAY 24 1943

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4267

CERTIFICATE OF DEATH

04268

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Penn</u>		COUNTY <u>Alleghany</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural-Annapolis</u>		DOA		TOWN <u>Pittsburgh</u>		75X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>7 Whitman</u> ✓			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>James</u>		(Middle) <u>A</u>		(Last) <u>GELSTON</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Cauc</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>		8. DATE OF BIRTH <u>2-20-37</u>	
				9. AGE last birthday <u>18</u> yrs.		10. IF UNDER 1 YEAR (Months) <u>17</u> Days <u>19</u> Hours <u>55</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>USN</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>James Patrick GELSTON</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>active duty</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS <u>USNH Records</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Injuries, Internal, multiple extreme # 869</u>				Immediate			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>7</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Highway</u>		21c. WHERE DID INJURY OCCUR? (City or town) <u>Rural-Annapolis</u> (County) <u>AA</u> (State) <u>MD</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>May 17 55</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Automobile Accident</u>			
22. I hereby certify that I attended the deceased from <u>5-17</u> , 19 <u>55</u> , to <u>5-17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-17</u> , 19 <u>55</u> , and that death occurred at <u>5-17</u> , 19 <u>55</u> , from the causes and on the date stated above.							
SIGNATURE <u>G.M. HILADI LCDR MC USNR</u>				DATE SIGNED <u>18 May 55</u>			
ADDRESS (Street, city, town, state) <u>U.S. Naval Hospital, Annapolis, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>May 18 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Pittsburgh, Pa.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>May 18, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>	

BUREAU V. S.

1955

121

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4268

CERTIFICATE OF DEATH

04269

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Odenton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location) <u>Waugh Chapel Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EDGAR</u>		(Middle) <u>R</u>		(Last) <u>GEORGE</u>		(Month) (Day) (Year) <u>May 30 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 12, 1884</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machinist</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William E. George</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>214-22-8047</u>		17. INFORMANT & ADDRESS <u>Mrs Mary M. George- Wife- same as # 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>42</u> IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						<u>45 min</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchiectasis</u>						<u>15 yrs.</u>	
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 28</u> , 19 <u>55</u> , to <u>May 30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 28</u> , 19 <u>55</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Edward J. [Signature]</u> M.D. ADDRESS (Street, city, town, state) <u>Residence 1111 [Address]</u> DATE SIGNED <u>5-31-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Waugh Chapel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Odenton, Maryland</u>	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>			

2. A. 092001

10. 000001

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4269

CERTIFICATE OF DEATH

04270

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
10. TOWN <u>ANNAPOLIS</u>				<u>Millersville, Md.</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ANNE ARUNDEL Gen</u>				STREET ADDRESS (if rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>LUCY</u> (First) <u>GRAY</u> (Middle) (Last)				<u>5</u> (Month) <u>8</u> (Day) <u>1955</u> (Year)			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>Colored</u>	<u>Widowed</u>	<u>8-27-1884</u>	<u>70</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		<u>None</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Chapman</u>				14. MOTHER'S MAIDEN NAME <u>Julia Garrett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) [If Yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>NO</u>						<u>EVA THOMAS Millersville Md</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
434.1 IMMEDIATE CAUSE (A) <u>Cor. Cardiac Failure</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> el work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.							
SIGNATURE <u>Oscar H MacNamee, MD</u>				DATE SIGNED <u>Millersville Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-11-55</u>		<u>John Wesley</u>		<u>Waterbury, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 11, 1955</u>		<u>[Signature]</u>		<u>William Bassett</u>		<u>10422 Washington St. ANNAPOLIS, Maryland</u>	

2. 1000

1907

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04271

4293

CERTIFICATE OF DEATH

Reg. Dist. No.

Items 13, 14, Film G182 6-3-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>aa</i>		MARYLAND		COUNTY <i>aa</i>			
CITY OR TOWN <i>Tracy</i>		LENGTH OF STAY (in this place) <i>4 yrs</i>		CITY OR TOWN <i>Tracy</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>60</i>				STREET ADDRESS (if rural give location) <i>1</i>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Susie Hall</i>				<i>May 9 1955</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widow</i>	8. DATE OF BIRTH <i>DEC 15 1896</i>	9. AGE last birthday <i>58</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>AA Co MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Catherine Hall 47 Calver St. Annapolis</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Cerebral Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Myocardial Fibillation</i>				<i>24 hrs</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Hypertensive CV Disease</i>				<i>unk</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1955</i> to <i>May 9, 1955</i> that I last saw the deceased alive on <i>9 May, 1955</i> and that death occurred at <i>10 P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>J. R. Darcce</i>				ADDRESS (Street, city, town, state) <i>Hyattsville Md 11 May 55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>5/12/55</i>		NAME OF CEMETERY OR CREMATORY <i>Union Chapel</i>	
24. REC'D BY REGISTRAR				25. FUNERAL DIRECTOR'S SIGNATURE <i>McKendree</i>		ADDRESS	
DATE <i>May 11, 1955</i>				REGISTRAR'S SIGNATURE <i>Ben West</i>		THIRD COPY SIGNATURE <i>Thomas Hardisty</i>	

S. A. D. 100

CH. 100

100 100 100

4294

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

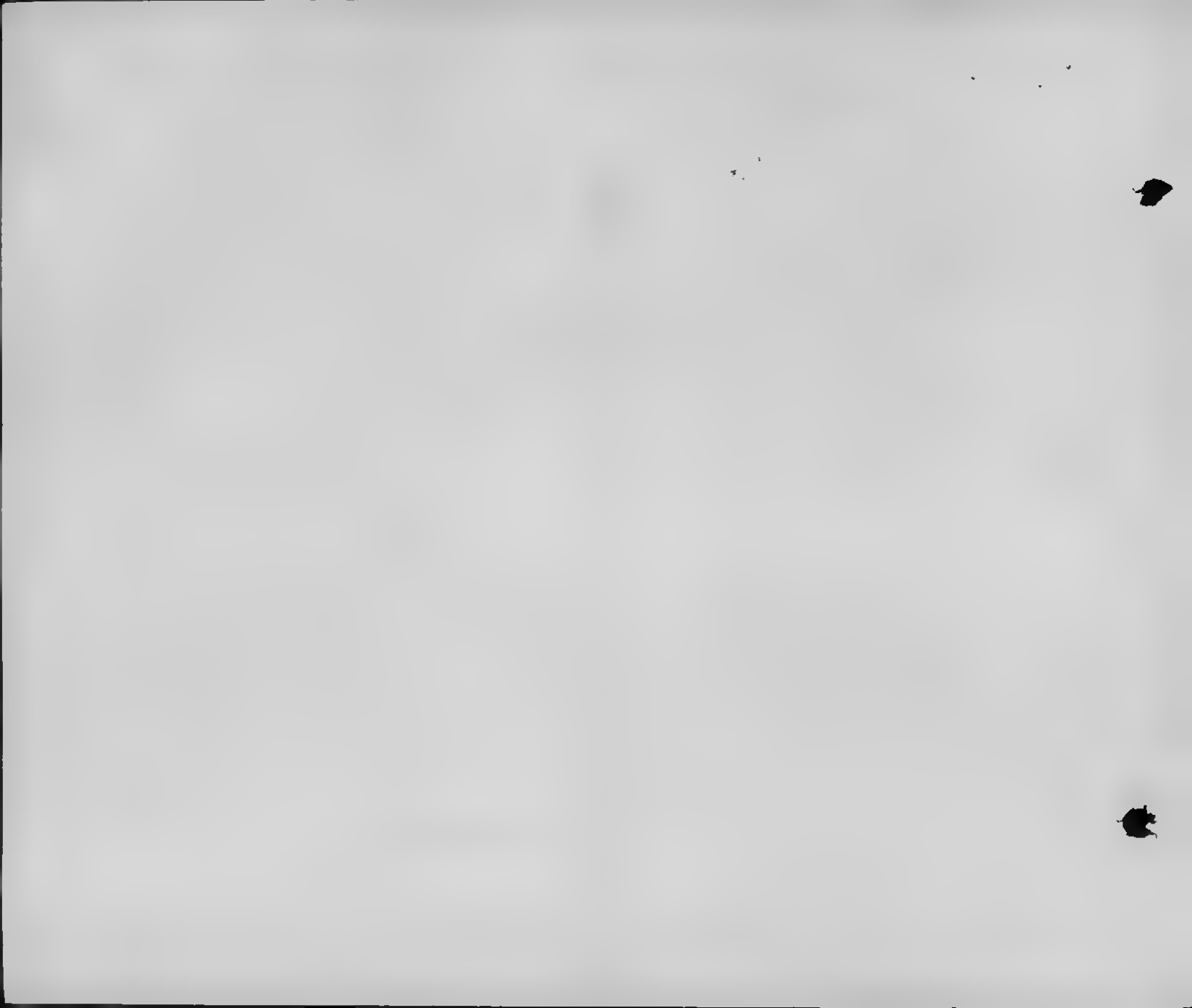
04272

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Brooklyn Park</u> LENGTH OF STAY (In this place) <u>15 minutes</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> <u>301-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Andalys of water - in the ground sand beach, Pot.</u>		STREET ADDRESS (If rural, give location) <u>1331 - Andalusia St.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>James Daniel Randy</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 24 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH <u>12/29/33</u>
9. AGE last birthday <u>21</u> yrs.		10. AGE last birthday If under 1 year: Months Days Hours Mins.	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Randy</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Lee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes, 1950</u>		16. SOCIAL SECURITY NO. <u>215-20-1262</u>	
17. INFORMANT AND ADDRESS <u>John Randy (father)</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>9298 Immediate cause</u> (a) <u>Accidental poisoning</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) (c)	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>U</u>		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <u>X</u>		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Andalusia St.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5/24/55 6:30 P.M.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>poisoning</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
22. I certify that I took charge of the remains described above, held an Autopsy Inspection <u>X</u> Inquiry <u>X</u> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <u>X</u> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Michael J. Paulus MD</u>		ADDRESS <u>1348 N. Calhoun St.</u>	
DATE SIGNED <u>5/24/55</u>			
23. FINAL CREMATION OR BURIAL (Specify) <u>Buried</u>		DATE THEREOF <u>May 27, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Balto nat</u>		LOCATION (City, town, or county) (State) <u>and</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>8-26-55</u>		24. FUNERAL DIRECTOR'S ADDRESS <u>George S. Nelson 1348 N. Calhoun St.</u>	

MARGIN RESERVE FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4295

CERTIFICATE OF DEATH

04273

Reg. Dist. No. 28

Item 22 Film 181 5-19-55 et

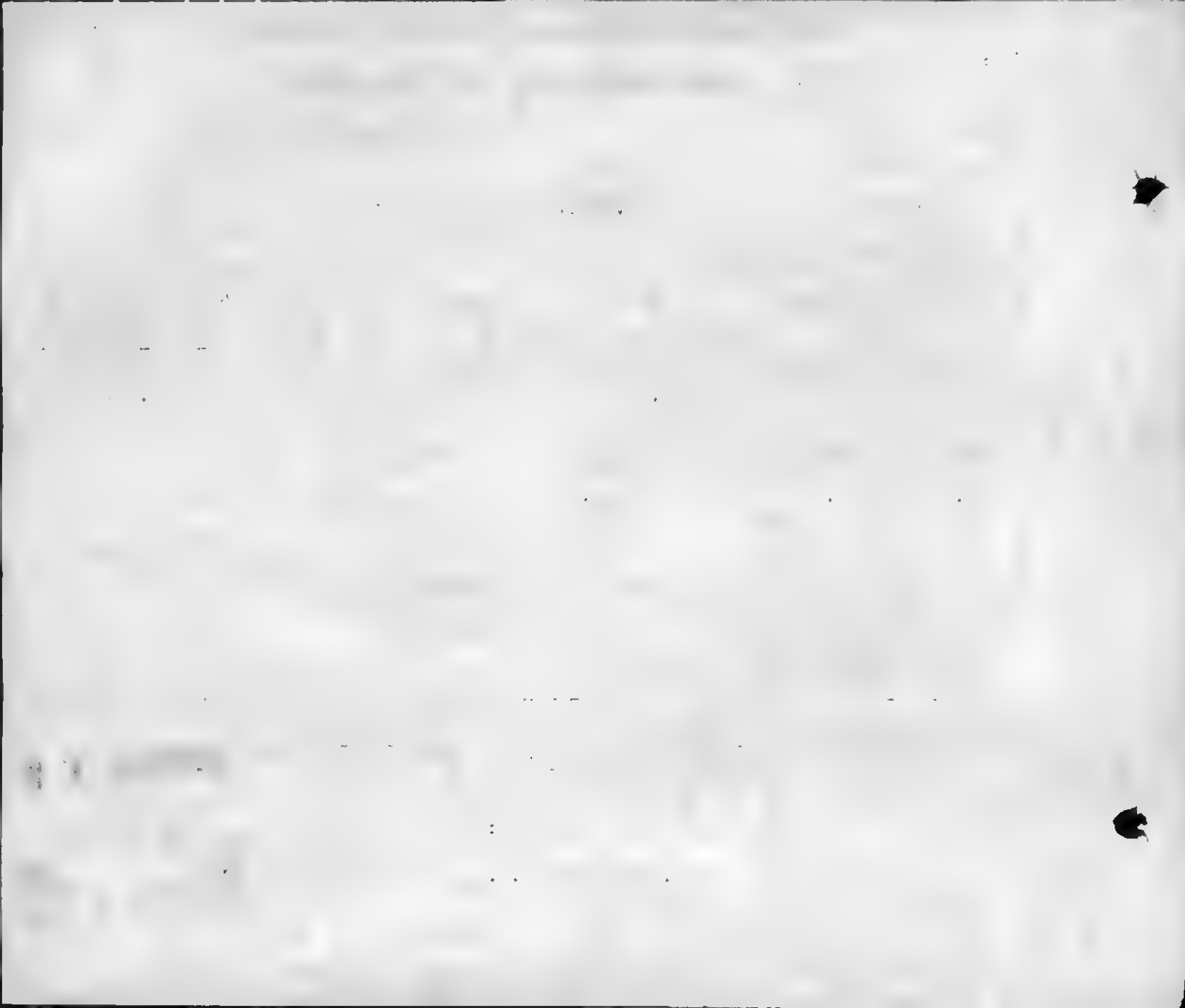
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Cecil	
CITY OR TOWN Crownsville		LENGTH OF STAY (in this place) 1 yr. 6 mos. 19 days		CITY (If outside corporate limits, write RURAL and give nearest town) Cecilton		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural give location) Box 32			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Eva		(Middle) May		(Last) Harris		(Month) 5 (Day) 16 (Year) 19 55	
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 10/4/86	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months 5 Days 16	IF UNDER 24 HRS. Hours 19 Min. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry			10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Absalom Greenby				14. MOTHER'S MAIDEN NAME Hester A. Gunby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT & ADDRESS Hospital Records			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 134.3 Cardiac Arrest				INTERVAL BETWEEN ONSET AND DEATH 6 months on Infirmary			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Emaciation of long standing							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. DUE TO (C)							
19a. DATE OF OPERATION 0		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 5/16		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/23/53 , to 5/16 , 19 55 , that I last saw the deceased alive on 5/16 , 19 55 , and that death occurred at 12:20 P.M. from the causes and on the date stated above.							
SIGNATURE (L. Benedict, M.D.)				ADDRESS (Street, city, town, state) Crownsville, Md.		DATE SIGNED 5/16/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried		DATE THEREOF May 19, 1955		NAME OF CEMETERY OR CREMATORY Cecilton Cem.		LOCATION (City, town, or county) (State) Cecilton Md.	
24. REC'D BY REGISTRAR R M J		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE Edward Fellers		ADDRESS	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4296 Items 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17 5-16-55 et
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04274
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 26

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Anne Arundel</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Fair Haven</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Fair Haven</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>1</i>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <i>William</i> (Middle) <i>Irish</i> (Last) <i>Herbert</i>		5-9-1955	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>11-1-79</i>
9. AGE last birthday: <i>75</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Type setter</i>	
10b. KIND OF BUSINESS OR INDUSTRY: <i>U. S. Gov.</i>		11. BIRTHPLACE (State or foreign country): <i>Washington, D. C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME: <i>James Herbert</i>	
14. MOTHER'S MAIDEN NAME: <i>Julia Cannon</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>Yes Spanish American None</i>	
16. SOCIAL SECURITY No.: <i>None</i>		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Coronary artery occlusion</i> DUE TO			
Antecedent cause(s) (b) <i>Generalized arteriosclerosis</i> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) DUE TO			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Emily H. Lism, M.D.</i>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>5-10-55</i> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial - Arlington Natl. Cemetery</i>	DATE THEREOF <i>May 13, 1955</i>	NAME OF CEMETERY OR CREMATORY <i>Arlington Natl. Cemetery</i>	LOCATION (City, town, or county) (State) <i>Arlington Va.</i>
DATE REC'D BY LOCAL REG. <i>May 10-55</i>	REGISTRAR'S SIGNATURE <i>D. B. Dent</i>	24. FUNERAL DIRECTOR <i>Warner E. Humphrey, Inc.</i> ADDRESS <i>Spring Rd.</i>	

4270

CERTIFICATE OF DEATH

04275

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY <u>ANNAPOLIS</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ann Arundel Gen. Hosp.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>AA</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Edgewater</u> STREET ADDRESS (If rural give location) <u>Woodland Beach</u>			
3. NAME OF DECEASED (Type or Print) <u>Jeanette</u> (First) <u>Hoot</u> (Middle) (Last)				4. DATE OF DEATH <u>May 21</u> 19 <u>55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Dec 30 - 1890</u>	9. AGE last birthday <u>64</u> yrs.	10. UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Alex. Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Sriefuss</u>				14. MOTHER'S MAIDEN NAME <u>Hellie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Mrs Cecil Boswell Woodland Beach</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) <u>coronary heart disease</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>arterosclerotic heartdis.</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>hypertension, ga. arterioscl.</u> STATING UNDERLYING CAUSE LAST. <u>8 years</u>						19. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 15</u> , 19 <u>57</u> , to <u>May 22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 22</u> , 19 <u>55</u> , and that death occurred at <u>3:20 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edith Roeller</u>				ADDRESS (Street, city, town, state) <u>45 Franklin St. Annapolis</u>		DATE SIGNED <u>5-22-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/18/55</u>		NAME OF CEMETERY, OR CREMATORY <u>Arlington Natl.</u>		LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u>		ADDRESS <u>517 11th St SE</u>	
DATE <u>May 23, 1955</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BURTON A. A.

MAY 20 1975

REGISTERED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04276

4271

CERTIFICATE OF DEATH

Reg. Dist. No. ... 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>		<u>28 days</u>		TOWN <u>Eastport</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u>				STREET ADDRESS (If rural give location) <u>1019 Tyler Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Etta B HOWARD</u>				<u>May 2 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>CAU</u>	<u>M</u>	<u>7-29-82</u>	<u>72</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Hezekiah BOWEN</u>				<u>Edith HARDESTY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk</u>				<u>USNH Records</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>586X</u> IMMEDIATE CAUSE (A) <u>MYOCARDIAL FAILURE ACUTE NOS 782.4</u>				<u>30 min.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>OBSTRUCTION COMMON BILE DUCT NOS 586</u>				<u>10 weeks</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White at work Not white at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4 March</u>, 19<u>55</u>, to <u>2 May</u>, 19<u>55</u>, that I last saw the deceased alive on <u>2 May</u>, 19<u>55</u>, and that death occurred at <u>9:55P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>P. O. Geib</u>				DATE SIGNED			
<u>P. O. GEIB, LCDR, USN.</u>				<u>M.D. U.S. Naval Hospital, Annapolis, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF GEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/3/55</u>		<u>Ushury Methodist</u>		<u>Barstow, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>May 5, 1955</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>[Address]</u>	



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4297

CERTIFICATE OF DEATH

04277

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MARYLAND</u>		COUNTY <u>ANNE ARUNDEL</u>			
CITY OR TOWN <u>RURAL - Glen Burnie</u>		LENGTH OF STAY (in this place) <u>13 yrs.</u>		CITY OR TOWN <u>RURAL - Glen Burnie, Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rfd #1 - Severn PO Md</u>				STREET ADDRESS (if rural give location) <u>Rfd #1 - Severn PO Md</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Ida</u> (Middle) <u>VERDIELLA</u> (Last) <u>HESTER</u>				(Month) <u>MAY</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>APRIL 24, 1862</u>	9. AGE last birthday <u>93</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hahn Tobb</u>				14. MOTHER'S MAIDEN NAME <u>Hood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>HERBERT JAMES HESTER</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u>						<u>5 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						<u>20 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>						<u>20 yrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Renal Failure</u>						<u>5 yrs</u>	
19a. DATE OF OPERATION <u>—</u>		19b. MAJOR FINDINGS OF OPERATION <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>—</u>		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21h. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>11:00 PM</u> <u>4/19/55</u> to <u>5:21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/20</u> , 19 <u>55</u> , and that death occurred at <u>11:03 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. W. Prichard</u>		M.D. <u>T. H. Cotter</u>		ADDRESS (Street, city, town, state) <u>Glen Burnie, Md</u>		DATE SIGNED <u>5/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 24/55</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Rd. - A. A. Co.</u>		LOCATION (City, town, or county) (State) <u>Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>L. J. D'Amico</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		ADDRESS <u>Glen Burnie, Md</u>	
DATE <u>May 23, 1955</u>							

1000

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04278

CERTIFICATE OF DEATH

Reg. Dist. No. 21

4272

1. PLACE OF DEATH

COUNTY

ANNE ARUNDEL

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

10 ANNAPOLIS

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

ARUNDEL GENERAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

MARYLAND COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

Baltimore

STREET ADDRESS

(If rural give location)

1647 W. NORTH AVE. #11

3. NAME OF DECEASED

(Type or Print)

(First)

(Middle)

(Last)

Hubert (NMI)

Jordan

4. DATE

(Month)

(Day)

(Year)

DEATH

5

20

1955

5. SEX

male

6. COLOR OR RACE

negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

MARRIED

November 23, 1901

9. AGE last birthday

53 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

COOK

10b. KIND OF BUSINESS OR INDUSTRY

UNION MEMORIAL

11. BIRTHPLACE (State or foreign country)

TAMPA FLORIDA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

577-14-9819

17. INFORMANT & ADDRESS

Bernice Jordan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

IMMEDIATE CAUSE

(A)

Cerebral Hemorrhage

ANTECEDENT CAUSE(S) DUE TO

(B)

Due to cerebral artery hardening

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

Cardiovascular disease

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

ONSET AND DEATH

May 19, 1955

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 19, 1955, to May 20, 1955, that I last saw the deceased

alive on May 20, 1955, and that death occurred at 10:50 P.M. from the causes and on the date stated above.

SIGNATURE

R. L. Richardson

M.D.

110 - 614 1/2 S. Ave. #11, Baltimore

ADDRESS (Street, city, town, state)

DATE SIGNED

5/30/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

DATE THEREOF

5/23/55

NAME OF CEMETERY OR CREMATORY

WOODLAND

LOCATION (City, town, or county)

WASHINGTON D.C.

24. RECD. BY REGISTRAR

REGISTRAR'S SIGNATURE

Thos. J. French

25. FUNERAL DIRECTOR'S SIGNATURE

Arllivaton S. Phillips 1808 N. MON. ST.

DATE

May 25, 1955

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 70M

ROBERT V. B.

MAY 25 1955

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04279

4273

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Nr Annapolis</u>				TOWN <u>nr Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>Riva Road</u>				<u>Riva Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last) <u>JAUNITA KELLER</u>				MAY 10, 1955 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Sept. 23, 1901</u>	<u>53</u> yrs	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>house wife</u>		<u>own home</u>		<u>Abingdon, Va.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Ben Ball</u>				<u>Sallie Sage</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>no</u>		<u>Mr. Clarence Keller, Husband; same as #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
174X IMMEDIATE CAUSE (A) <u>Cancer of uterus</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<u>?</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 6, 1955</u> to <u>May 10, 1955</u> , that I last saw the deceased alive on <u>May 10, 1955</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Mamie Klemans</u> M.D.				ADDRESS (Street, city, town, state) DATE SIGNED <u>5/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>May 11, 55</u>		<u>to</u>		<u>Abingdon, Virginia</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 11, 1955</u>		<u>[Signature]</u>		<u>[Signature]</u>		<u>HOPPING FUNERAL HOME, ANNAPOLIS, MD.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

7 12 13 14 15

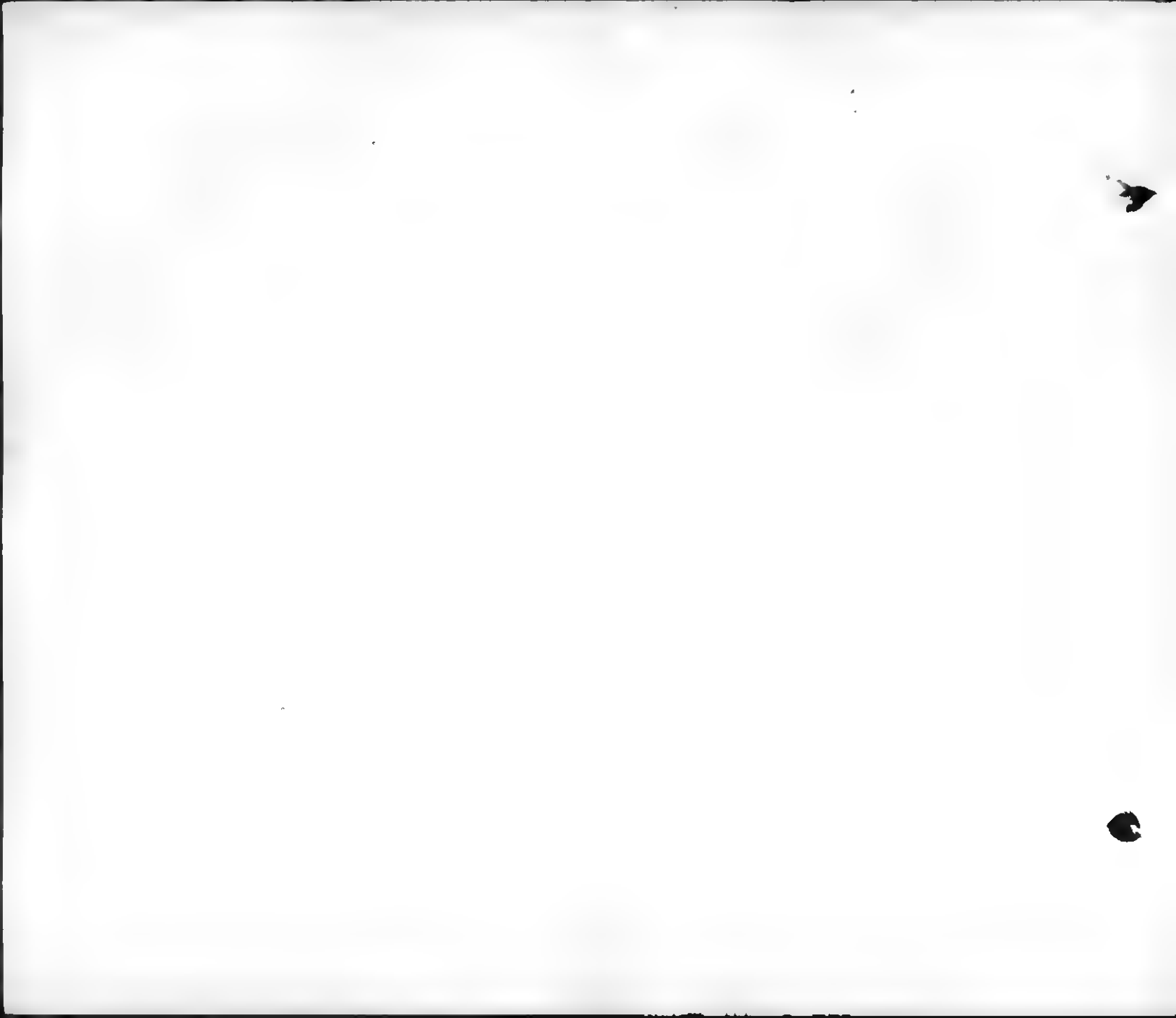
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04280
4298 CERTIFICATE OF DEATH Reg. Dist. No. 2

1. PLACE OF DEATH: COUNTY <u>A.A.</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Brooklyn Park</u> TOWN <u>Brooklyn Park</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4400 Ritchie Highway</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>A.A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Brooklyn Park</u> STREET ADDRESS (If rural give location) <u>4400 Ritchie Highway</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MARY C. KNIPP</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>5/9/55</u> <u>19</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify): <u>W</u>		8. DATE OF BIRTH: <u>6/1/72</u>	
9. AGE last birthday: <u>82</u> yrs.				10. IF UNDER 1 YEAR: Months Days Hours Min.		11. IF UNDER 24 HRS. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME: <u>Julian Cote</u>			
14. MOTHER'S MAIDEN NAME: <u>Juila Bourquian</u>				15. INFORMANT & ADDRESS: <u>Family - Same</u>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>				17. SOCIAL SECURITY NO.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>155X</u> IMMEDIATE CAUSE (A) <u>Generalized Carcinomatosis</u> ANTECEDENT CAUSE (S) DUE TO <u>Carcinoma of Gall Bladder</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/5</u> , 19 <u>54</u> , to <u>5/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/8</u> , 19 <u>55</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above. SIGNATURE <u>Edward C. Knipp</u> M. D. DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>B</u>				DATE THEREOF <u>5/11/55</u>			
NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>				LOCATION (City, town, or county) (State) <u>Baltimore</u>			
DATE REC'D BY LOCAL REGISTRAR <u>5-16-55</u>				REGISTRAR'S SIGNATURE <u>Edw. C. Knipp</u>			
24. FUNERAL DIRECTOR <u>James L. McCully</u>				ADDRESS <u>130 E. Fort Ave.</u>			

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4299

CERTIFICATE OF DEATH

04281

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY **Anne Arundel**CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Severn**HOSPITAL OR INSTITUTION OR STREET ADDRESS **S. Crain Highway Box 77**

MARYLAND

LENGTH OF STAY (in this place) **35 years**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Same.**

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Same**STREET ADDRESS **Same** (If rural give location)3. NAME OF DECEASED: (First) **Bernard**

(Middle)

Kruszewski

(Last)

4. DATE (Month) (Day) (Year)

OF DEATH **May 25 1955**

19

5. SEX:

M.

6. COLOR OR RACE:

W.7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) **Widowed**

8. DATE OF BIRTH:

12/18/1876

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS

78 yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired **Retired farmer**

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Stanislaus kruszewski

14. MOTHER'S MAIDEN NAME:

Coniconda mennix15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) **NO**

16. SOCIAL SECURITY No.:

None

17. INFORMANT & ADDRESS:

James kruszewski (son).

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X
Immediate cause(a) **Cerebral hemorrhage****33 hrs.**

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) **hypertensive cardio vascular diseases.****5 y.**

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **January 19. 50** to **5/25/55**, 19, that I last saw the deceasedalive on **5/24/55**, and that death occurred at **4.15 P.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

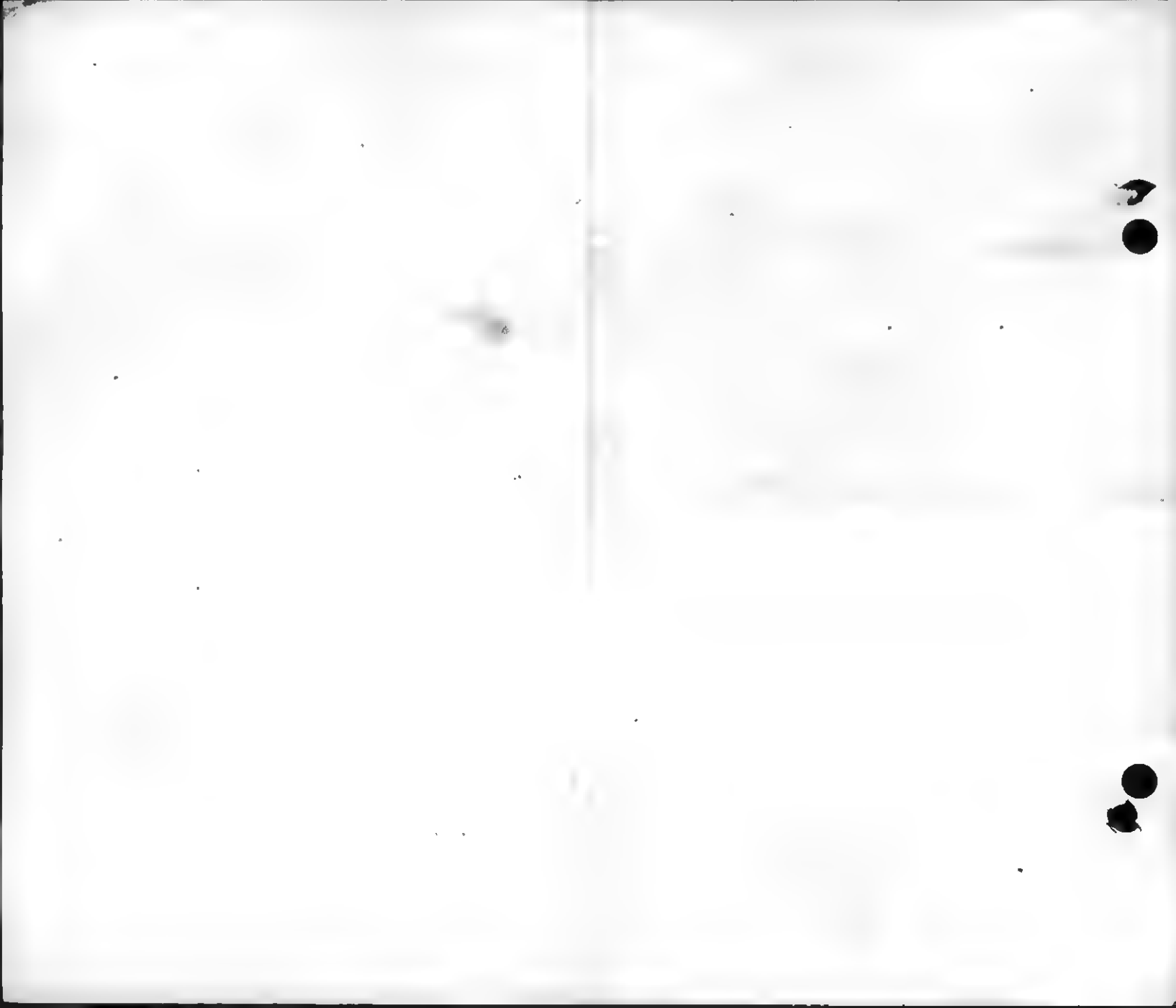
24. FUNERAL DIRECTOR

ADDRESS

Burial 5/28/55 Sacred Heart Mary Balto. Co. Md. 5/25/55**3-20-55 Dr. Hedrick Mrs. S. Fialkowski 2007 Eastern Ave**

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04282

4274 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ANNAPOLIS</u>				TOWN <u>CROWNSVILLE</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>63 A. A. GENERAL HOSPITAL</u>				<u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>HELEN</u> (Middle) <u>BREWSTER</u> (Last) <u>LOVELL</u>				(Month) <u>5</u> (Day) <u>20</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>WHITE</u>	<u>WIDOW</u>	<u>6-30-1884</u>	<u>70</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>HOUSE WIFE</u>		<u>HOME</u>		<u>MAYWOOD Ill.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>GEORGE W. BREWSTER</u>				<u>MARY LEWIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>-</u>		<u>FRANK B. LOVELL SEVERNA PARK MD</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
446X IMMEDIATE CAUSE (A) <u>Uremia due to Nephrosclerosis</u>				<u>36 hr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bone Marrow suppression</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Radioactive phosphorus</u>				<u>6 yr.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<u>2</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 18, 1955</u> , to <u>5/20/1955</u> , that I last saw the deceased alive on <u>5/20/1955</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Frank M. Skelley</u>		<u>Annapolis Md</u>		<u>5/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5-23-55</u>		<u>Baltimore Memorial</u>		<u>Mallersville Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>May 23, 1955</u>		<u>U. Daniel</u>		<u>Jim W. Taylor Sons</u>		<u>Annapolis Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

100-100000

MAY 1955

100-100000

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. This bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4390

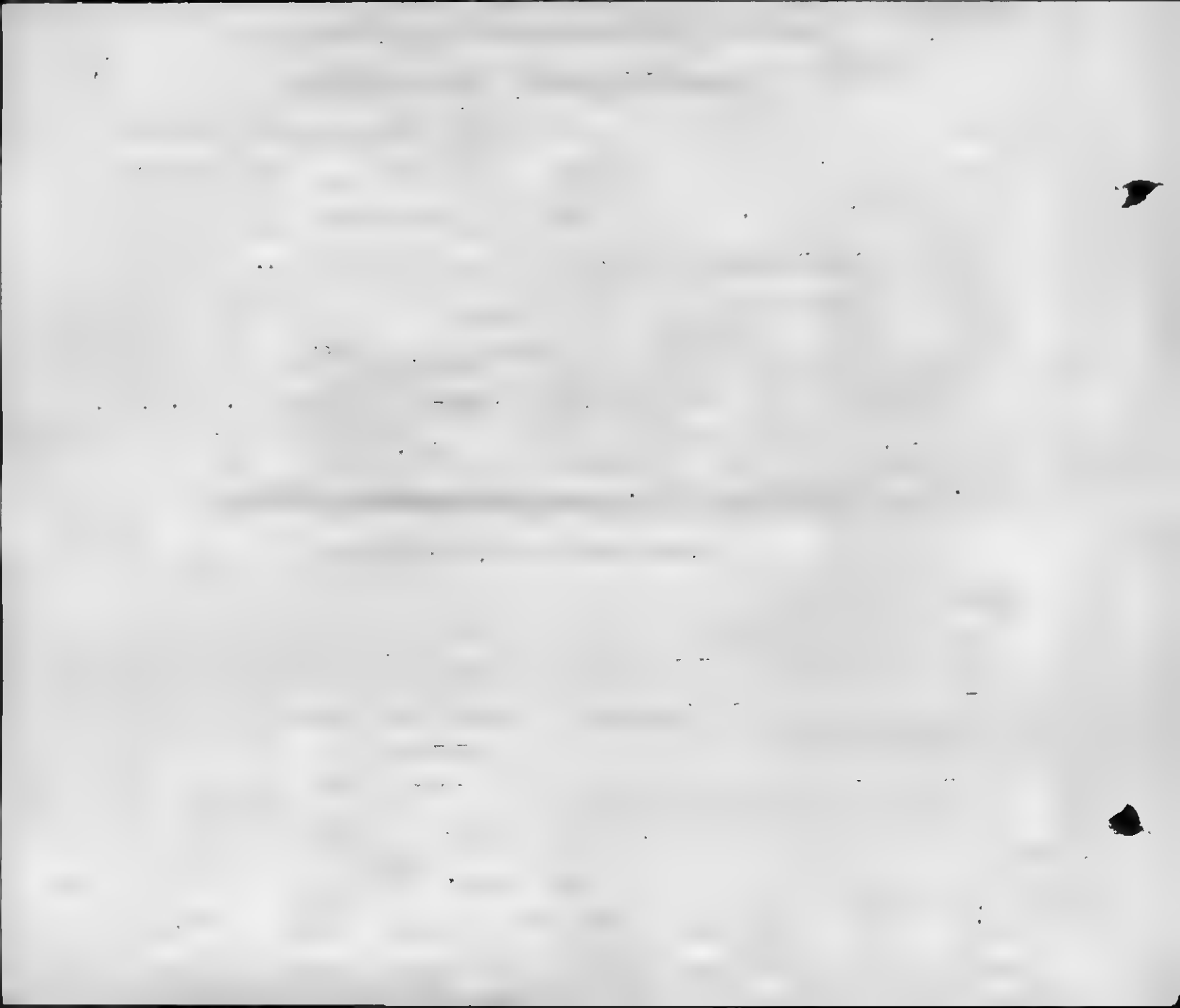
CERTIFICATE OF DEATH

04283

Reg. Dist. No.

From 89: film Q182 6/7/52

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Crownsville Md.		LENGTH OF STAY (In this place) 22 hours		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore		TOWN 3rd 4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural give location) 1635 Ruxton Ave.			
3. NAME OF DECEASED (Type or Print) Augustus Mackel				4. DATE OF DEATH (Month) (Day) (Year) May 28, 1955			
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1904	9. AGE last birthday 51 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk. Laborer		10b. KIND OF BUSINESS OR INDUSTRY Water front		11. BIRTHPLACE (State or foreign country) Unknown - Calvert Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk. Albert Mackel				14. MOTHER'S MAIDEN NAME unk. Ella McDaniels			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.		16. SOCIAL SECURITY NO. unk.		17. INFORMANT & ADDRESS Hospital Record			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH 25 days	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Pulmonary Tuberculosis, Far advanced							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 5/28		19b. MAJOR FINDINGS OF OPERATION ---		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ---		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) ---			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) ---		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? ---			
22. I hereby certify that I attended the deceased from 5/27 , 19 55 , to 5/28 , 19 55 , that I last saw the deceased alive on 5/28 , 19 55 , and that death occurred at 2:30 PM , from the causes and on the date stated above.							
SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city, town, state) L. Benedict		DATE SIGNED 5/29/ 55	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 6/2/55		NAME OF CEMETERY OR CREMATORY Int Auburn		LOCATION (City, town, or county) (State) Baltimore Md.	
24. REC'D BY REGISTRAR May 31, 1955		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home		ADDRESS 1631 David Hill Ave.	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4275

CERTIFICATE OF DEATH

04284

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince George</u>	
CITY OR TOWN <u>Annapolis</u> (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place) <u>2 days</u>		CITY OR TOWN <u>Hall</u> (If outside corporate limits, write RURAL and give nearest town)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>CHARLES A MARTIN</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 21 19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>May 19, 1955</u>	9. AGE last birthday <u>-</u> yrs. <u>-</u> months <u>2</u> days	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Neal Martin</u>				14. MOTHER'S MAIDEN NAME <u>Goldie Cox</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Neal Martin-Father- same as # 2</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>754.4 IMMEDIATE CAUSE (A) Congenital Heart Disease</u>				<u>2 days.</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 19</u> , 19 <u>55</u> , to <u>May 21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>55</u> , and that death occurred at <u>8:50 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Merritt</u>				ADDRESS (Street, city, town, state) <u>62 m br 113</u>		DATE SIGNED <u>5-21-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>May 22, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Thomas Cemetery</u>		LOCATION (City, town, or county) (State) <u>Lee County, Virginia</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>	
DATE <u>MAY 22, 1955</u>				2055 384407			

BUREAU V. S.

MAY 25 1955



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been examined by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4301

CERTIFICATE OF DEATH

04285

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Ohio</u>		COUNTY <u>Seneca</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Ft George G. Meade</u>		<u>11 months</u>		TOWN <u>Bloomville</u>		<u>72 x - -</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Army Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Angela</u> - <u>MC CLELLAND</u>				<u>14</u> <u>May</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>14 May 1955</u>			<u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>		<u>-</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Frederick N. McClelland</u>				<u>Anne Marie L. Burtzlauff</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Mrs. Frederick N. McClelland</u> <u>021 Park Ave, Apt 214, Laurel, Maryland</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<u>Prematurity</u>				<u>5 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>14 May 55</u>		<u>14 May 55</u>					
22. I hereby certify that I attended the deceased from <u>0145 14 May 55</u>, to <u>0620 14 May 55</u>, that I last saw the deceased alive on <u>14 May</u>, 19<u>55</u>, and that death occurred at <u>0620</u> M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Joseph S. Ardinger</u>				<u>14 May 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>				<u>Post Cemetery</u>		<u>Ft GG Meade, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
<u>16 May 55</u>		<u>Arthur J. Gordon, CAPT., MSC</u>		<u>CHAP. QUIGLEY, Ft GG Meade, Md.</u>			

2055292-40

RECEIVED

1911

NOV 10 1911

4276

CERTIFICATE OF DEATH

04286

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anna Arundel		MARYLAND		STATE Maryland		COUNTY 10	
CITY OR TOWN 10 Annapolis		LENGTH OF STAY (In this place)		CITY OR TOWN Annapolis		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 03 Boyd Drive Hillsme'e Shore				STREET ADDRESS Boyd Drive Hillsme'e Shore		(If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Melva M. Mitchell				4. DATE OF DEATH (Month) (Day) (Year) May 10, 1955			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH August 29, 1895	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John William Grimm				14. MOTHER'S MAIDEN NAME Emma V. Grimm			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-03-5667		17. INFORMANT & ADDRESS Oscar C. Mitchell Boyd Drive Hillsme'e Shore Annapolis, Md.			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
237X IMMEDIATE CAUSE (A) Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 3 days			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) Tumor of Brain				8 months			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION C		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 1955, to 5-9-1955, that I last saw the deceased alive on 5-9-1955, and that death occurred at 2:15 P.M. from the causes and on the date stated above.							
SIGNATURE James R. Mark		M.D.		ADDRESS (Street, city, town, state) Annapolis, Md.		DATE SIGNED 5/10/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) removal		DATE THEREOF 5/13/55		NAME OF CEMETERY OR CREMATORY Beaver Cemetery		LOCATION (City, town, or county) (State) Beaver, Pennsylvania	
24. REC'D BY REGISTRAR DATE May 12, 1955		REGISTRAR'S SIGNATURE J. J. Daniel		25. FUNERAL DIRECTOR'S SIGNATURE The S. H. Davis Co.		ADDRESS 2901 14th St. N.W. Washington, D.C.	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUCKLEY V. S.

10-1-1911

4302

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04287
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
<input checked="" type="checkbox"/> TOWN <u>Edgewater</u>				TOWN <u>Washington, D.C.</u>		<u>47 x .2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>South River</u>				STREET ADDRESS (If rural, give location) <u>420 Buchanan St. NW</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JOSEPH PETER MONALDO</u>				<u>MAY 25, 19 55</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>March 30, 1937</u>	
9. AGE last birthday: <u>18 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>High School</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Student</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Biagio Monaldo</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Ullisse</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mr Biagio Monaldo- Father- same as # 2</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
850.X Immediate cause (a) <u>Drowning</u> DUE TO						<u>Within</u>	
Antecedent cause(s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office, etc.) <u>Edgewater</u>		21c. (City or town) (County) (State) <u>Anne Arundel Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 19, 55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>boat turned over</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that Death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>May 25, 1955</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>May 27, 55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REG <u>May 26, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Deal Funeral Home</u>		ADDRESS <u>4812 Georgia Ave. NW Washington, D.C.</u>	

MARGIN RESERVED FOR MINING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 X 4

1955

10

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-35 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

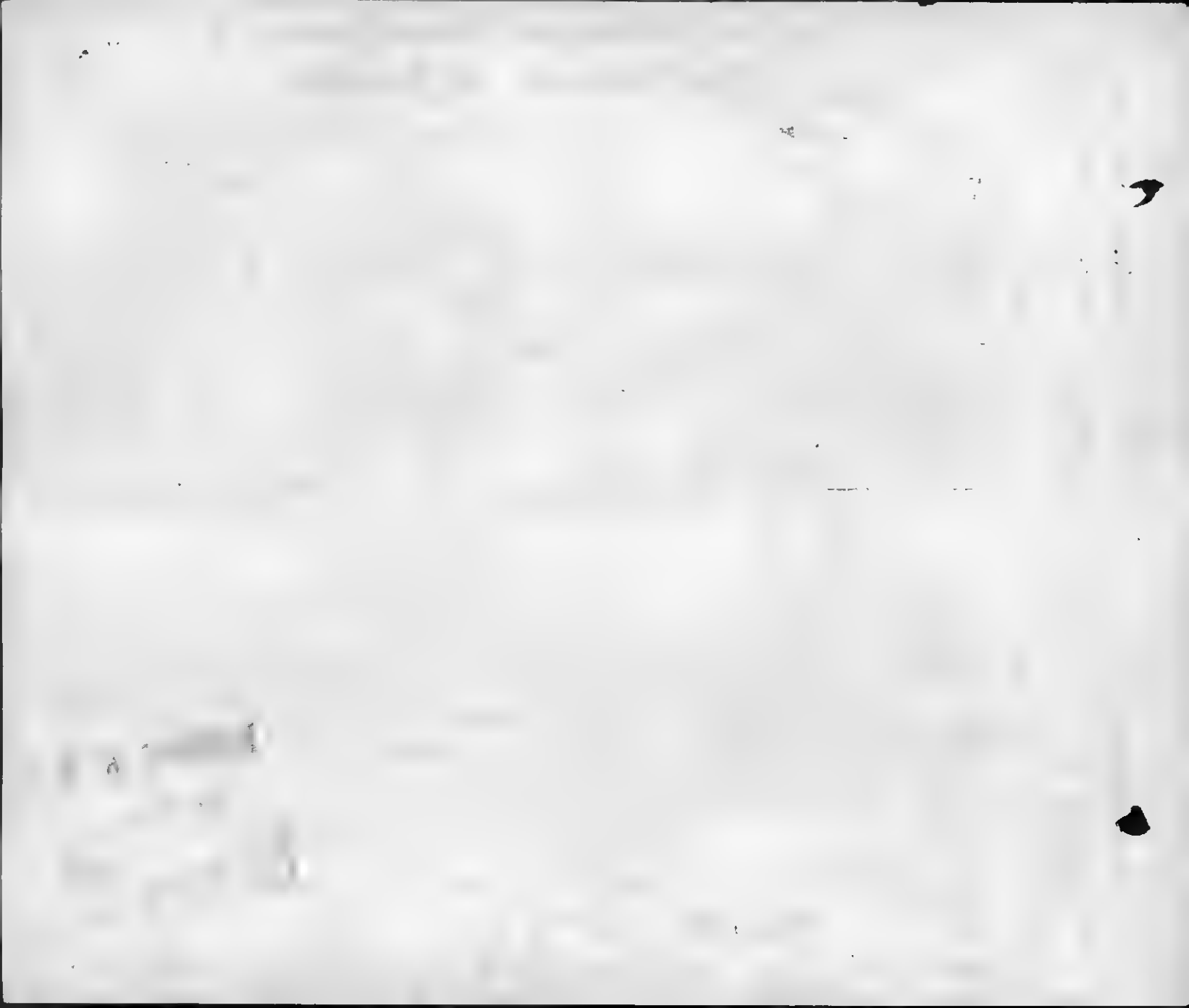
04288

4277

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		STATE MARYLAND		STATE Maryland		COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOLIS		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 63 ANNE ARUNDEL GENERAL				STREET ADDRESS (If rural give location) 310 Chesapeake Ave			
3. NAME OF DECEASED (First) (Middle) (Last) ALBERT F MONDAY				4. DATE OF DEATH (Month) (Day) (Year) MAY 14, 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married but separated	8. DATE OF BIRTH Sept. 18, 1889	9. AGE last birthday 65 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter		10b. KIND OF BUSINESS OR INDUSTRY House painting		11. BIRTHPLACE (State or foreign country) Rockville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas F. Monday				14. MOTHER'S MAIDEN NAME Ida King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-05-2055		17. INFORMANT & ADDRESS Mrs Lucile Fisher-Daughter; same as # 2			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Pulmonary Tuberculosis						?	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Admission to hospital		?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5/10 , 19 55 , to 5/14 , 19 55 , that I last saw the deceased alive on 5/14 , 19 55 , and that death occurred at 5:55 P.M. from the causes and on the date stated above.							
SIGNATURE Maurice Klawns M.D.				ADDRESS (Street, city, town, state) Annapolis, Md 5/16/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 17, 1955		NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		LOCATION (City, town, or county) Annapolis, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE 10 - D. Daniel		25. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS ANNAPOLIS, MD.	
DATE May 17, 1955							



1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04289

CERTIFICATE OF DEATH

Reg. Dist. No. 21

4303

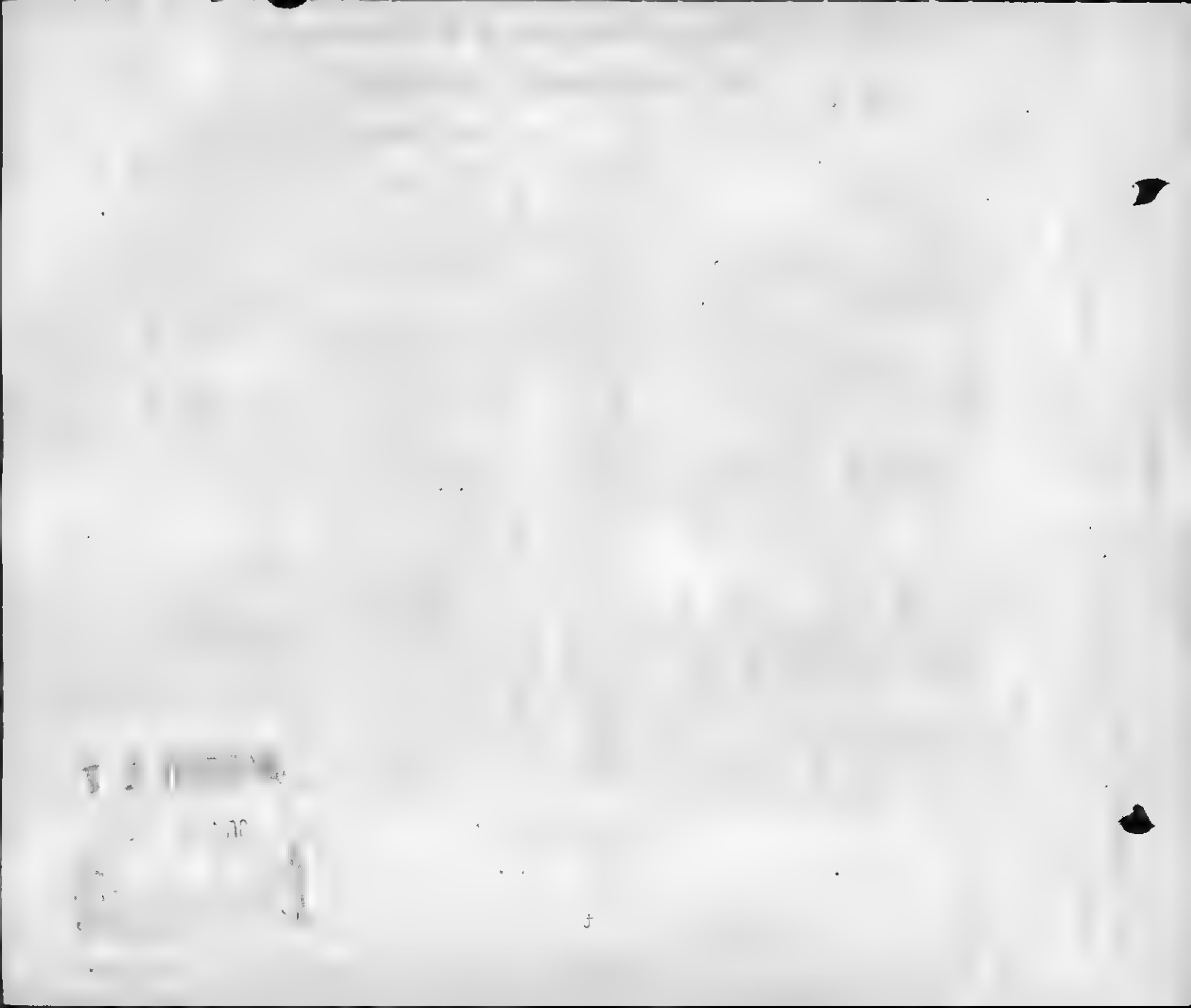
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Rural</u>		<u>DOA</u>		TOWN <u>Naval Station, Annapolis, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>USNH, Annapolis, Maryland</u>				STREET ADDRESS (If rural give location) <u>NAVAL STATION, ANNAPOLIS, MD</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Robert Gerald NELSON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>May 29 19 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>20 March 1934</u>	9. AGE last birthday <u>21</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USN</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>Emil Seigfried Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Etta Lenora (UNKNOWN)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>514 32 0635</u>		17. INFORMANT & ADDRESS <u>U.S. Naval Records</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
824X IMMEDIATE CAUSE (A) <u>Injuries, Multiple Extreme #869</u>						<u>Immediate</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Rural AA Md</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>May 29 553:15 am</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Automobile accident 1 P.M.</u>			
22. I hereby certify that I attended the deceased from <u>DOA</u> , 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>3:15 a.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Philip George Logan, M.D.</u>				DATE SIGNED <u>U.S. Naval Hospital, Annapolis, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>May 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>to</u>		LOCATION (City, town, or county) (State) <u>Axtell, Marshall County, Kansas</u>	
24. REC'D BY REGISTRAR <u>May 31, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



4304

04290
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

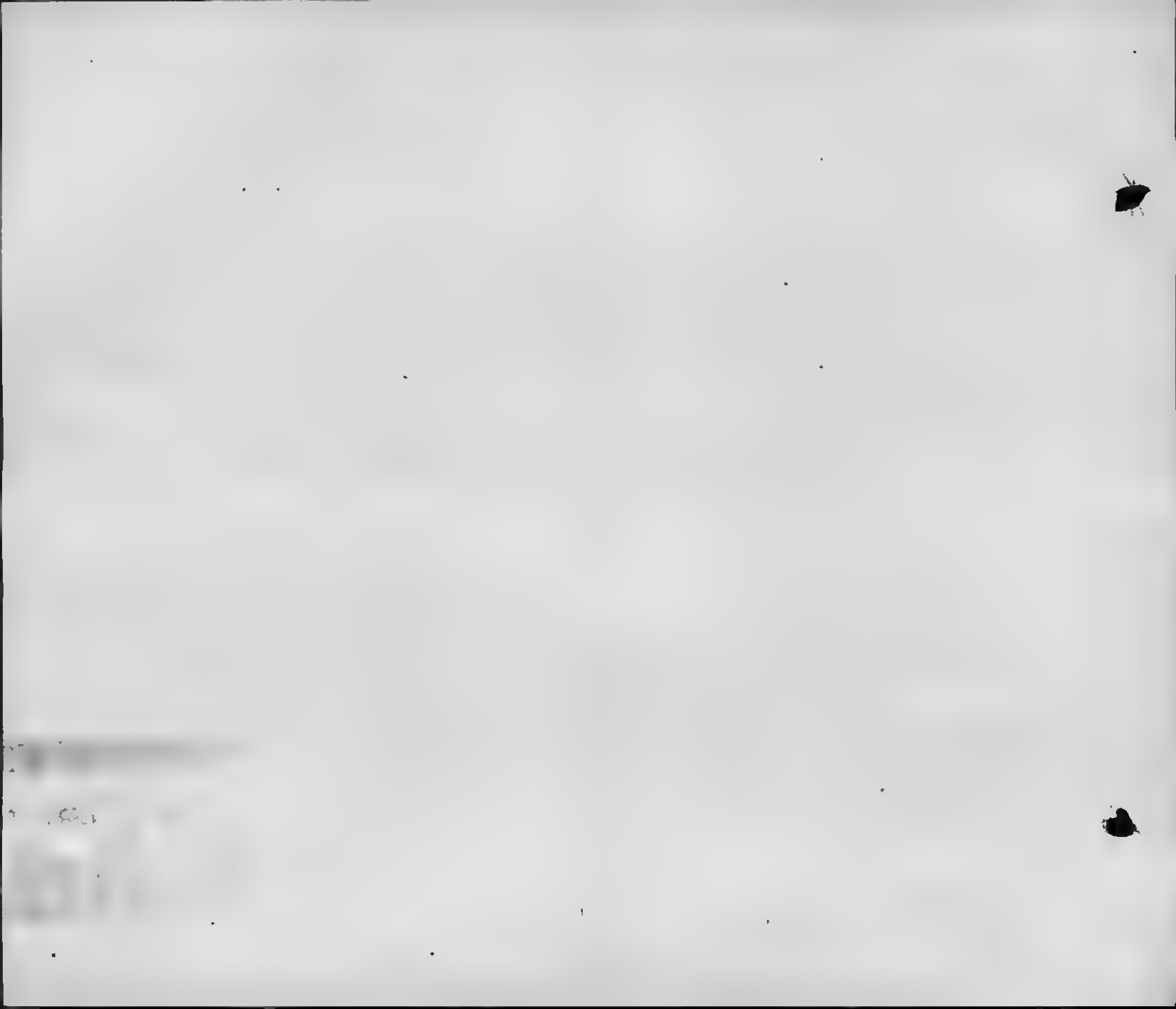
No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE		COUNTY <u>47X3</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Washington, D. C.</u>			
TOWN <u>Edgewater</u>				STREET ADDRESS (If rural, give location) <u>4300 Harewood Rd. N.E</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>South River</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>The Rev. Dominic Palladino</u>				<u>May 26, 19 55</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>Male</u>		<u>white</u>		<u>Single</u>		<u>August 23, 1919</u>	
						9. AGE last birthday: <u>35</u> yrs.	
						10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Priest</u>	
						11. BIRTHPLACE (State or foreign country): <u>Mass.</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Antonio Palladino</u>				14. MOTHER'S MAIDEN NAME: <u>Pasqualina Caggiano</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Personal papers</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
<u>850X</u> Immediate cause (a)..... <u>Drowning</u> DUE TO					
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>May 19, 1955</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>South river</u>		21c. (City or town) <u>Edgewater, Anne Arundel, Maryland</u>	
21d. TIME (Month) (Day) (Year) (Hour) <u>May 19, 1955</u> <u>AM</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>boat turned over</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>May 26, 1955</u>			
		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		DATE THEREOF <u>May 27, 55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Lawrence, Mass.</u>					
DATE REC'D BY LOCAL REG. <u>May 26, 1955</u>		REGISTERAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Ben L. Hopping and Son</u>	
				ADDRESS <u>Annapolis, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4305

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X <u>Crownsville</u>		<u>7 yrs/ 4 mos.</u>		TOWN <u>Baltimore City</u>		<u>3614</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>10 Crownsville State Hospital</u>				<u>707 Harlem Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>William Parker</u>				<u>5 2 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>Male</u>	<u>Negro</u>	<u>Single</u>	<u>1874</u>	<u>81</u> yrs.	Months	Days	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Farming</u>		<u>Maryland</u>		<u>U. S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Jim Parker</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Unk.</u>		<u>Unk.</u>		<u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Myocardial Insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH			
<u>451X</u>				<u>2 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>Aortic Aneurysm</u>				<u>2 weeks</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>---</u>		<u>---</u>		<u>---</u>		<u>---</u>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/5</u> , 19 <u>55</u> , to <u>5/2</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/2</u> , 19 <u>55</u> , and that death occurred at <u>3:15pm</u> , from the causes and on the date stated above.							
SIGNATURE <u>H. Legeard Heard Reissmann</u> (Reissmann)				ADDRESS (Street, city, town, state) <u>Crownsville, Md.</u>			
DATE <u>5/2/55</u>				DATE SIGNED <u>5/2/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>5/6/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Anns School</u>		LOCATION (City, town, or county) (State) <u>Balto. City Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>K. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Miss Henry 578 W. Bigale</u>		ADDRESS <u>St.</u>	
DATE <u>May 3 '55</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

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U.S. DEPT. OF AGRICULTURE

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

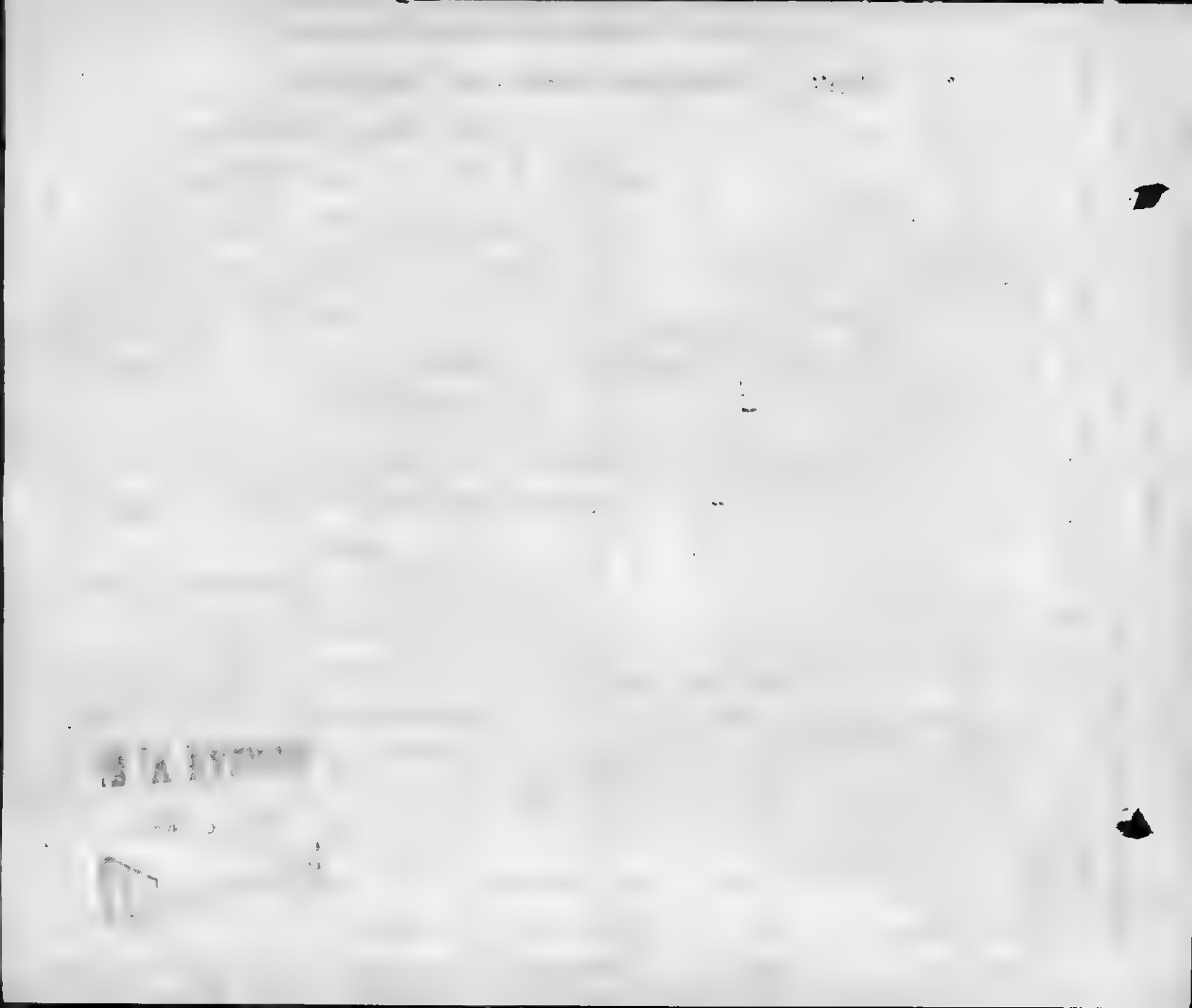
04292

4306

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>PP</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Churchton</i>		<i>6.5 years</i>		TOWN <i>Churchton</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Bessie Irene</i> (Middle) <i>Phlipps</i> (Last)				(Month) <i>May</i> (Day) <i>1</i> (Year) <i>1955</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>F</i>	<i>W.</i>	<i>Married</i>	<i>June 17 1886</i>	<i>68</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>				<i>Deale Md.</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>John Ford</i>				<i>Margaret Virginia Rodgers</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>no</i>		<i>none</i>		<i>William Lance Phlipps, Churchton Md.</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A)				<i>Cerebral Vascular Accident</i>			
ANTECEDENT CAUSE(S) DUE TO				<i>Cerebral Arteriosclerotic Disease</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<i>48 hrs</i>			
				<i>Unk</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3:00 PM</i> , 19 <i>55</i> , to <i>1:00 PM</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>3:00 PM</i> , 19 <i>55</i> , and that death occurred at <i>1:30 PM</i> , from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<i>Wm Lance Phlipps</i>				<i>Upper Marlboro Md</i>		<i>269-5</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>May 3 1955</i>		<i>Truher</i>		<i>Galesville Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>5-4-55</i>		<i>Elvis West Williams</i>		<i>Bernard Hardisty</i>		<i>Galesville Md.</i>	



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4307

CERTIFICATE OF DEATH

04293

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY AA		MARYLAND		STATE Md.		COUNTY AA	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Millersville (Rural)		2 weeks		TOWN Glen Burnie (Rural)		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
90 Sand's Nursing Home				Oakwood Rd.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
Esther Elizabeth Praley				May 25 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
F	W	Married	January 5, 1920	35 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		own home		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James Wood				Emma Stenmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		219 - 16 -1673		Oakwood Rd. Frank J. Praley, Jr, Glen Burnie, Md.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
17.2X IMMEDIATE CAUSE (A) Generalized Carcinomatosis							6 Mo
ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma of Brain							1 Year
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 12, 1955, to May 25, 1955, that I last saw the deceased alive on May 24, 1955, and that death occurred at 5:30 AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
Edward J. Thier				Glen Burnie, Md.		5-25-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial				Glen Haven Memorial		Glen Burnie, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE May 26, 1955		James A. Hopping		Hopping and Kirkley, Glen Burnie, Md.			

S. A. DVT 401

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4308

CERTIFICATE OF DEATH

04294

Reg. Dist. No. 23

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Linthicum Hgts.</u>		<u>2 mos.</u>		TOWN <u>Linthicum Hgts</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
<u>209 Devon Court</u>				<u>209 Devon Court</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Charles</u> (Middle) <u>Henry</u> (Last) <u>Ray</u>				(Month) <u>May</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>Nov. 29, 1868</u>	<u>86</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer (ret.)</u>		<u>A. A. County</u>		<u>Anne Arundel Co., Md</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John H. Ray</u>				<u>Sarah M. Magruder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. Annie A. Ray</u> <u>209 Devon Court</u> <u>Linthicum Hgts. Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
592X IMMEDIATE CAUSE (A) <u>Coro-vascular Disease</u>						<u>3 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Intestinal Infection</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> <u>1955</u> , to <u>May 11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 11</u> , 19 <u>55</u> , and that death occurred at <u>5:25</u> P.M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>James S. Beallengier</u>				<u>108 Central Ave. Glen Burnie Md</u>		<u>May 13, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Apr 14 1955</u>		<u>Cedar Hill Cem.</u>		<u>Brooklyn, NFD Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DATE 7 May 19, 1955</u>		<u>Goldwell Hoodruff</u>		<u>R. V. Singleton, Jr.</u>		<u>209 Devon Court</u>	
		<u>L. J. De Alba.</u>					

ROBERT A. S.

MAY 20

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4309

04295

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY ARUNDEL MARYLAND CITY OR TOWN GLEN BURNIE HOSPITAL OR INSTITUTION OR STREET ADDRESS PLAZA MINOR CONVALESCENT HOME ROUTE 2 Box 376A				2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD COUNTY CITY OR TOWN BALTIMORE 30114 STREET ADDRESS 3116 BARCLAY ST. ✓			
3. NAME OF DECEASED (Type or Print) CECELIA (First) RAZAR (Last)				4. DATE OF DEATH May 20 19 55			
5. SEX F	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, MARRIED	8. DATE OF BIRTH FEB. 9-1888	9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		10b. KIND OF BUSINESS OR INDUSTRY SCHOOL		11. BIRTHPLACE (State or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME BENJAMIN CONNOR				14. MOTHER'S MAIDEN NAME NELLIE TERRY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. MRS. CATHERINE ST. CLAIR 2044 RUXTON AVE.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE (A) Cardiac failure ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic heart disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) ARTERIOSCLEROTIC				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 19, 1955 to May 20, 1955 that I last saw the deceased alive on May 20, 1955 and that death occurred at 9:00 A.M. from the causes and on the date stated above. SIGNATURE Joseph Taler M.D. ADDRESS (Street, city, town, state) 102 BALTIMORE-ANNAPOLIS BLVD. N.E. GLEN BURNIE, MD. DATE SIGNED 5/20/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
Burial		5-23-1955		St. Mary		Baltimore, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE May 24, 1955		Louis J. DeAlba		Funeral Home 1631 Smith Hill Ave.			

BUREAU V. N.

MAY 24 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

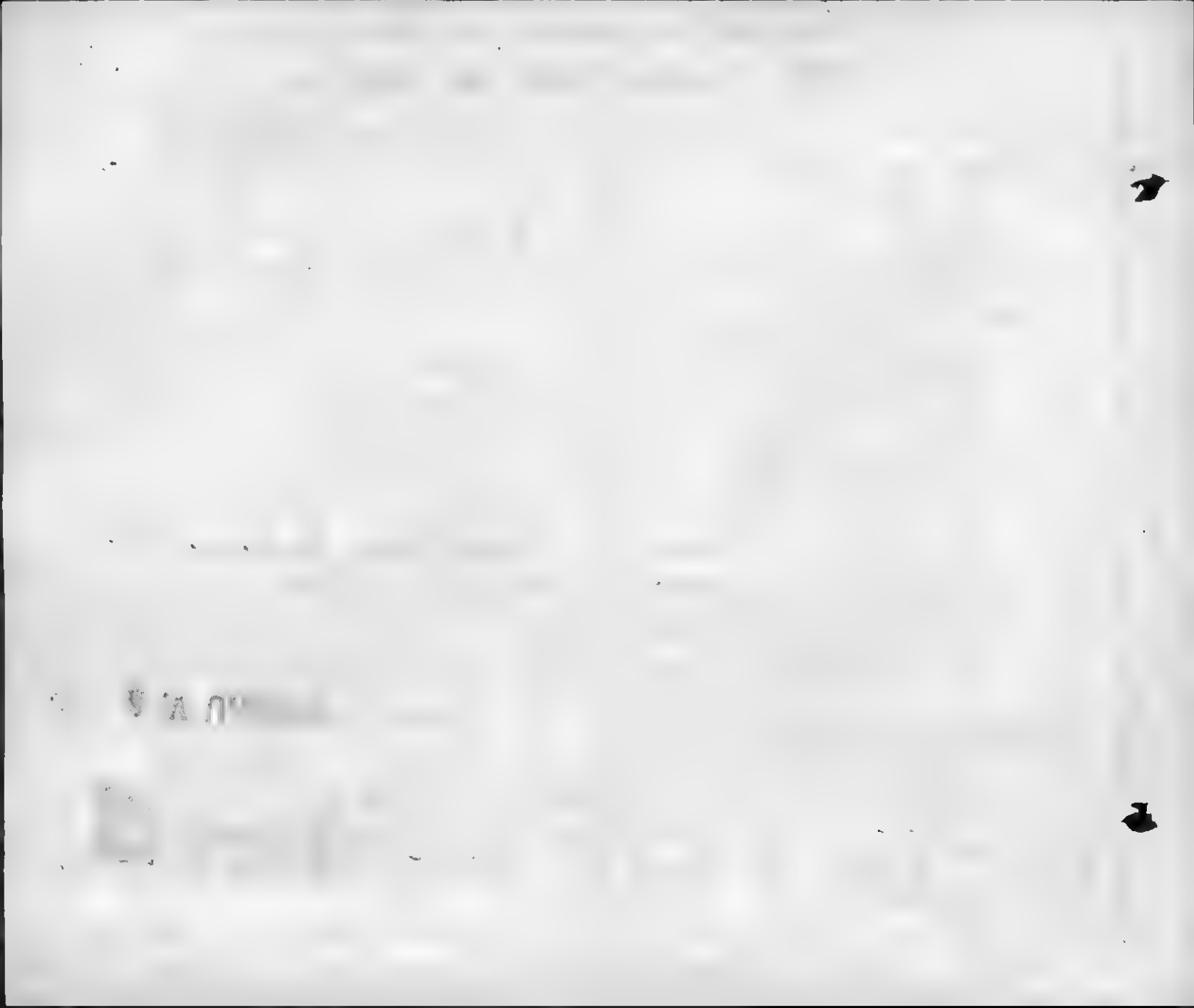
4310

CERTIFICATE OF DEATH

04296

Reg. Dist. No. 23

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Linthicum</u>		<u>2 yrs.</u>		TOWN <u>Linthicum</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>708 Camp Meade Road</u>				STREET ADDRESS (If rural give location) <u>708 Camp Meade Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Sarah</u> (Middle) <u>Estelle</u> (Last) <u>Rice</u>				(Month) <u>May</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Feb-17-1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Philadelpia, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John P. Rice</u>				<u>Mary E. Steigleman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Mrs. Ester E. Boblitz</u>		<u>708 Camp Meade Rd. Linthicum, Md.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
170x IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO				<u>5 yrs -</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>0</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3:10</u>, 19<u>52</u>, to <u>5:25</u>, 19<u>55</u>, that I last saw the deceased alive on <u>5/25</u>, 19<u>55</u>, and that death occurred at <u>1:30 P.</u>M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Chas. L. Ball</u>				<u>Linthicum Md.</u>		<u>5/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>May 27/55</u>		<u>Baldwin Mem. Ch. Cem.</u>		<u>Anne Arundel Co. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>May 31, 1955</u>		<u>Dr. Caldwell Woodruff</u>		<u>W. K. Singleton</u>		<u>Shenandoah, Md.</u>	
		<u>L. Deaeba</u>					



4311

CERTIFICATE OF DEATH

Reg. Dist. No.

04297

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<input checked="" type="checkbox"/> TOWN <u>Elyaton</u>		OR TOWN <u>Millersville, P. O.</u>	<input checked="" type="checkbox"/>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
		<u>Box 207</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH: (Month) (Day) (Year)	
(First) <u>ALBERT</u>	(Middle) <u>HENRY</u>	(Last) <u>ROSS</u>	<u>May 1, 19 55</u>
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Nov. 5, 1897</u>
9. AGE last birthday: <u>57</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>1</u> Hours <u>17</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>Maintenance</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Ft. Meade</u>	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Samuel Thomas Ross</u>		14. MOTHER'S MAIDEN NAME: <u>Ruth Mary Henry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>L</u>	
17. INFORMANT & ADDRESS: <u>Mr. Morris Ross- Eldersburg, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.0 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>		3 mos.	
ANTECEDENT CAUSE (S) (B) <u>Arteriosclerotic Heart Disease</u>		2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/24, 1953</u> to <u>5/1, 1955</u> that I last saw the deceased alive on <u>5/1, 1955</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Albert J. Schockel</u>		ADDRESS <u>4111 Liberty Heights Ave</u> DATE SIGNED <u>5/2/55</u>	
M. D. <u>Balto., Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/4/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. J. Dickener</u>	
		FUNERAL DIRECTOR <u>Wm. J. Dickener</u> ADDRESS <u>Sous Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



4312

CERTIFICATE OF DEATH

04298

Reg. Dist. No. 24

Item 8, Film 182 6-6-55 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Glen Burnie</u>				TOWN <u>Glen Burnie</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 39 - Oakwood Rd.</u>				STREET ADDRESS (If rural give location) <u>Box 39 Oakwood Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Gertrude</u>				4. DATE OF DEATH (Month) <u>5</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>1913</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>counter (ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stand. Equip. Co.</u>		9. AGE last birthday <u>41</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Ba. Md.</u>	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-20-0426</u>		17. INFORMANT & ADDRESS <u>John Ruskie</u> <u>Oakwood Rd</u> <u>Glen Burnie</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
1. IMMEDIATE CAUSE (A) <u>Melanoma - Sarcoma & Metastasis</u>						8 Mos.	
2. ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>5</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> 19 <u>55</u> , to <u>May</u> 19 <u>55</u> , that I last saw the deceased alive on <u>May 26</u> , 19 <u>55</u> , and that death occurred at <u>6:45</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Dr. MacDonald MD</u>				ADDRESS (Street, city, town, state) <u>Glen Burnie, Md.</u>		DATE SIGNED <u>5-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 1, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. REC'D BY REGISTRAR <u>May 31, 1955</u>		REGISTRAR'S SIGNATURE <u>L. J. D'Alto</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>TR Klinghoffer</u>		ADDRESS <u>Glen Burnie, Md.</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1870

DATE RECEIVED BY THE OFFICE OF THE ATTORNEY GENERAL

7-1-17

1990

... ..

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04299

27

Reg. Dist. No.

4313

CERTIFICATE OF DEATH

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Illinois</u>		COUNTY <u>Will</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort George G. Meade</u>		<u>2 Years</u>		TOWN <u>Joliet</u>		<u>51X-5</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>--</u>			
3. NAME OF DECEASED				4. DATE OF DEATH			
(First) <u>JOHN</u>		(Middle) <u>---</u>		(Last) <u>SABOTNIK</u>		(Month) (Day) (Year) <u>May 31 19 55</u>	
(Type or Print)							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>December 16, 1878</u>	
						9. AGE last birthday <u>76</u> yrs.	
						IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Officer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>State Penitentiary</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Anton Sabotnik</u>				14. MOTHER'S MARDEN NAME <u>Agnes Slansek</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>---</u>				16. SOCIAL SECURITY NO. <u>330-05-4138</u>		17. INFORMANT & ADDRESS <u>Lt. Col Rex E. Sabotnik</u> <u>1502 Ingalls Road</u> <u>Glen Burnie, Maryland</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>154X</u> IMMEDIATE CAUSE (A) <u>Adenocarcinoma of rectum re-current in Colostomy</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Adenocarcinoma of rectum</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>---</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>							
19a. DATE OF OPERATION <u>11 October 1954</u>				19b. MAJOR FINDINGS OF OPERATION <u>Adenocarcinoma of Rectum with metastasis carcinoma of</u>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>---</u>				21b. PLACE (Home, farm, factory, or INJURY strael, office bldg., etc.) <u>---</u>		21c. WHERE DID INJURY OCCUR? <u>pelvic lymph nodes</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>---</u>				21e. INJURY OCCURRED While at work Not while at work <u>---</u>		21f. HOW DID INJURY OCCUR? <u>---</u>	
22. I hereby certify that I attended the deceased from <u>4 May</u> , 19 <u>55</u> , to <u>31 May</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>31 May</u> , 19 <u>55</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Myron Myers</u>				DATE SIGNED <u>31 May 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR <u>W. L. SAYLER, 1ST LT MSG</u>			
DATE <u>1 June 1955</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>THOMAS W. SINGLETON</u>			
				ADDRESS (Street, city, town, state) <u>Glen Burnie, Md.</u>			

RECEIVED

SEP 1955

100-100000

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4314

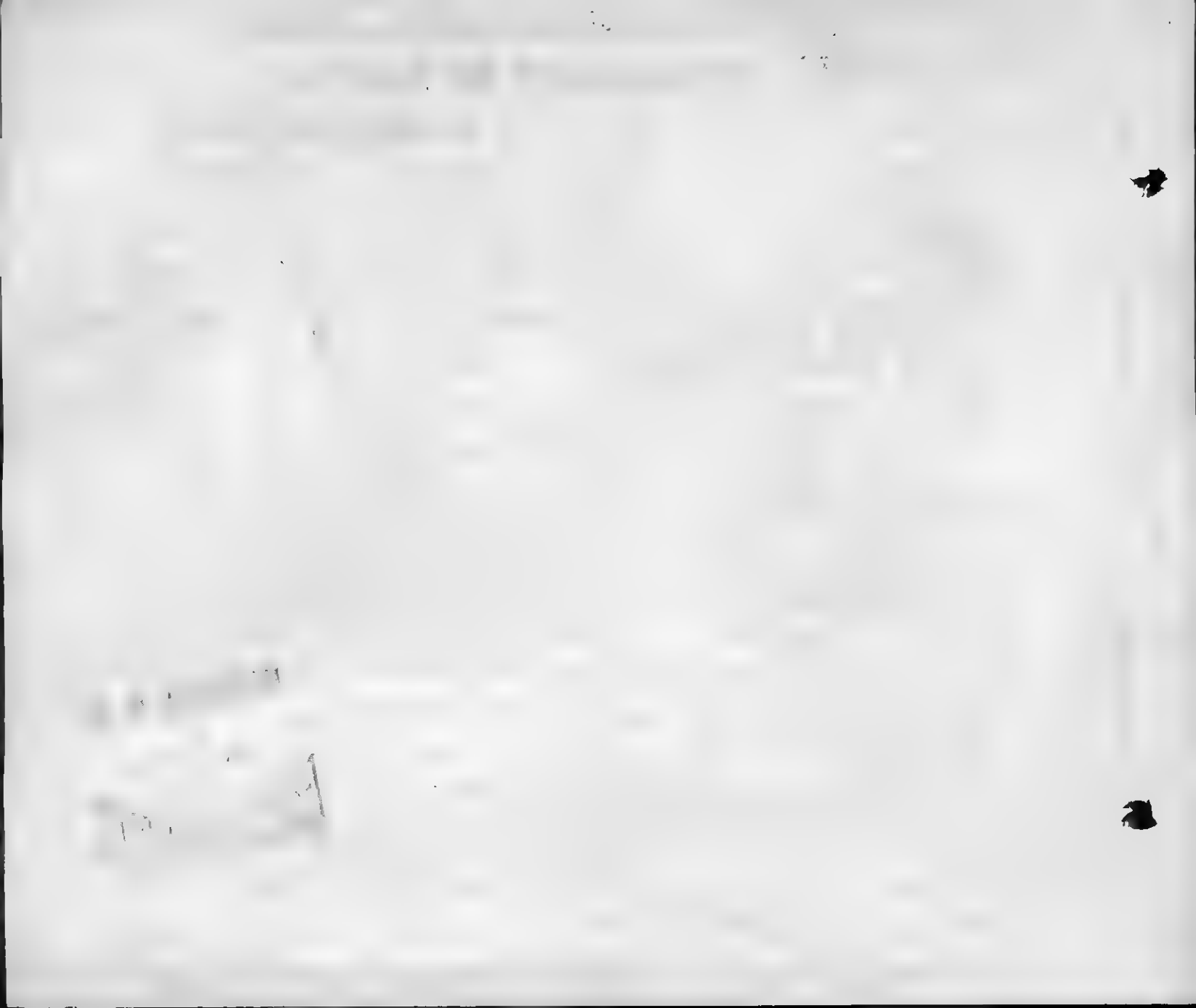
CERTIFICATE OF DEATH

04300

Item 12, Film G181, 5/13/55 foy

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Middleville</u>		<u>14 months</u>		TOWN <u>Edgewater</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sand Nursing Home</u>				STREET ADDRESS (If rural give location) <u>County Home</u>			
3. NAME OF DECEASED (Type or Print) <u>CHARLES FREDERICK SCHMIDT</u>				4. DATE OF DEATH <u>May 1 1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>UNKNOWN</u>		8. DATE OF BIRTH <u>Apr. 28-1877</u>	
9. AGE last birthday <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waiter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Welfare Records, Annapolis Md</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		2. IMMEDIATE CAUSE (A) <u>Cerebral Accident</u>		3. ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arterio sclerosis</u>		4. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	
5. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH		19a. DATE OF OPERATION <u>D</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>Jan 1955</u> to <u>May 1, 1955</u> , that I last saw the deceased alive on <u>April 29, 1955</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.		SIGNATURE <u>Edward G. Bennett</u> M.D.		ADDRESS (Street, city, town, state) <u>65mbills Md</u> DATE SIGNED <u>5-1-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 2, 55</u>		NAME OF CEMETERY OR CREMATORY <u>County Home</u>		LOCATION (City, town, or county) <u>Edgewater MD</u>	
24. REC'D BY REGISTRAR <u>May 1, 1955</u>		REGISTRAR'S SIGNATURE <u>Elcie Thst William Bernard Hardisty Saluwell</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Elcie Thst William Bernard Hardisty Saluwell</u>		ADDRESS	



4315

CERTIFICATE OF DEATH

04301

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>AA</u>	
CITY OR TOWN <u>Millersville (Rural)</u>		LENGTH OF STAY (in this place) <u>3 mos.</u>		CITY OR TOWN <u>Epping Forest, Annapolis, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sand's Nursing Home</u>				STREET ADDRESS (If rural give location) <u>/</u>			
3. NAME OF DECEASED (Type or Print) <u>Amanda Grace Sentman</u>				4. DATE OF DEATH (Month) <u>May</u> (Day) <u>29</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>July 14, 1867</u>		9. AGE last birthday <u>87</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mifflin Rowe</u>				14. MOTHER'S MAIDEN NAME <u>Deborah Sapp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Epping Forest, Annapolis, Md.</u> <u>Robert Sentman,</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Arterio sclerotic Heart Disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u></u>							
STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u></u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I attended the deceased from <u>Mar 28</u> , 19 <u>55</u> , to <u>May 29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 26</u> , 19 <u>55</u> , and that death occurred at <u>7:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Bennett</u>				ADDRESS (Street, city, town, state) <u>Lambertville, Md.</u>		DATE SIGNED <u>5-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>6/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Fernwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Philadelphia, Pa.</u>	
24. REC'D BY REGISTRAR <u>May 31, 1955</u>		REGISTRAR'S SIGNATURE <u>Nathaniel M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Kirkley</u> ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN-OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

U. S. A. 10000

10000

4278

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>a a</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>a a</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Annapolis</u>				TOWN <u>Lothian</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood Convalescent</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Caroline Elizabeth Shepherd</u>				OF DEATH: <u>May 28</u> 19 <u>55</u>			
5. SEX. <u>F</u>		6. COLOR OR RACE. <u>w</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>		8. DATE OF BIRTH <u>Feb 14</u>	
9. AGE last birthday <u>85</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<u>Sandwell, Md</u>			
13. FATHER'S NAME: <u>Joshua L. Higgins</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Cicquata Hommard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT'S ADDRESS: <u>Ralph Shepherd, Balt Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						7 days	
ANTECEDENT CAUSE (B) <u>Generalized Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>Decubitus Ulcers</u>						2+ m.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>1</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>home</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/24</u> , 19 <u>55</u> , to <u>5/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/28</u> , 19 <u>55</u> , and that death occurred at <u>1200</u> P. M., from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shipley</u>		ADDRESS <u>M. D. Annapolis</u>		DATE SIGNED <u>5/29/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>May 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St James</u>		LOCATION (City, town, or county) (State) <u>Troy, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 31, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Bennett Hardaway</u>		ADDRESS <u>Holmesville, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10

10

4316

CERTIFICATE OF DEATH

04303

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>A.A.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Mulberry Hill</u>				TOWN <u>Mulberry Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Felicia</u> (Middle) <u>SIMON</u> (Last)				(Month) <u>5</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Which)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>Colored</u>	<u>MARRIED</u>	<u>7-5-1885</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>ANNE ARUNDEL Co.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>HENRY COOK</u>				<u>HARRIET STANSBERRY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>UNK.</u>				<u>Daniel Simon, Mulberry Hill</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> Not at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5-5-55</u> to <u>5-11-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5-6-55</u> , 19 <u>55</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5-15-55</u>		<u>Broadneck</u>		<u>Skidmore, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 13, 1955</u>		<u>[Signature]</u>		<u>William Reese II 108 W. WASH. ST</u>		<u>ANNAPOLIS, Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

U. S.

4317

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH: <i>Funeral.</i>				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>A.A. Co.</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>A.A. Co.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural.</i>		LENGTH OF STAY (in this place) <i>20 yrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Home</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <i>Carrie</i> (Middle) (Last) <i>Snowden</i>				(Month) <i>May</i> (Day) <i>28</i> (Year) <i>1955</i>			
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>Colored</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>		8. DATE OF BIRTH: <i>Unk.</i>	
9. AGE last birthday: <i>about 75 yrs.</i>		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:		10b. KIND OF BUSINESS OR INDUSTRY: <i>Farm work.</i>		11. BIRTHPLACE (State or foreign country): <i>Unk.</i>	
13. FATHER'S NAME: <i>Unk.</i>				14. MOTHER'S MAIDEN NAME: <i>Unk.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>af.</i>		16. SOCIAL SECURITY No.: <i>None</i>		17. INFORMANT & ADDRESS: <i>William Reese -</i>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <i>Carbon. Vascular Disease</i>							
Antecedent causes (s) (b) <i>_____</i>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <i>_____</i>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>None</i>							
19a. DATE OF OPERATION: <i>C Home</i>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify) <i>None</i>		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>None</i>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>May 27</i> , 1955, to <i>May 28</i> , 1955, that I last saw the deceased alive on <i>May 27</i> , 1955, and that death occurred at <i>2 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>James S. Bellenger MD</i>				DATE SIGNED <i>May 31, 1955</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>6-4-55</i>		NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>June 4, 1955</i>		REGISTRAR'S SIGNATURE <i>L. J. DeAlba</i>		24. FUNERAL DIRECTOR <i>William Reese, 108 Washington St.</i>		ADDRESS <i>Annapolis, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 9 1955

105

4279 CERTIFICATE OF DEATH

04305

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10 TOWN <u>Annapolis</u>		28 years		TOWN <u>Rural</u>		<u>Pasadena</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
51 <u>U.S. Naval Academy</u>				<u>Box 178 Route 2</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Frederick Ferdinand STAEHLE (also Staehley)</u>				<u>5 23 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>10 January 1875</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Pipefitter</u>		<u>U.S. Government</u>		<u>Switzerland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Caspar Staehle</u>				<u>Amelia (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>Spanish-American</u>		<u>216-14-7172</u>		<u>Miss Fredda Staehle</u> <u>Box 178 Rt 2, Pasadena, Md. (Daughter)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Occlusion, coronary artery</u>						<u>120.1</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED White <input type="checkbox"/> at work Not white <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on.....5-23-1955....., and that death occurred at.....2:50 P.M., from the causes and on the date stated above.							
SIGNATURE <u>E. H. Martinat</u>				ADDRESS (Street, city, town, state) DATE SIGNED			
<u>E. H. MARTINAT LT (MC) USNR</u>				<u>M.D. U.S. Naval Academy, Annapolis, Md.</u> <u>5-23-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/26/55</u>		<u>Meadowridge Cem.</u>		<u>Howard Co.,</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 25, 1955</u>		<u>Wm. J. French</u>		<u>Wm. J. Tichenor & Sons - Back 17 Ma</u>			

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED

MAY 6

1954

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04306

4318

CERTIFICATE OF DEATH

Reg. Dist. No. *2*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Millersville</u>				TOWN <u>Gambrills</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sands Nursing Home</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JAMES</u> (Middle) <u>R</u> (Last) <u>STOCKETT</u>				(Month) <u>MAY</u> (Day) <u>20</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Sept. 30, 1866</u>	<u>88</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Farmer</u>		<u>Own Farm</u>		<u>Davidsonville, Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Benjamin Stockett</u>				<u>Emily Bean</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Mr. Marvin H. Stockett-Son-same as # 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
33'X IMMEDIATE CAUSE (A) <u>Cerebral Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>				<u>10 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 1954</u> to <u>May 20, 1955</u> , that I last saw the deceased alive on <u>May 19, 1955</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Hewitt</u>		M.D.		ADDRESS (Street, city, town, state) <u>Gambrills Md</u>		DATE SIGNED <u>5-20-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 23, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>All Hallows Cemetery</u>		LOCATION (City, town, or county) (State) <u>Davidsonville, A.A., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>H M Sage</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ben L. Hopping Jr.</u>		ADDRESS <u>HOPPING FUNERAL HOME ANNAPOLIS, MD.</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 12 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

U. S. A.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been examined by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4319

CERTIFICATE OF DEATH

04307

Reg. Dist. No. 22

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
X TOWN <u>Odenton</u>		<u>12 yrs.</u>		TOWN <u>Odenton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
1				1			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Floyd</u> (Middle) <u>Leander</u> (Last) <u>Tester</u>				<u>May</u> <u>13</u> <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>April 5, 1880</u>	<u>75</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Carpenter (ret.)</u>		<u>U.S. Gov't.</u>		<u>Johnson City, Tennessee</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Elkora Tester</u>				<u>Mary Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>U.S. Gov't.</u>		<u>Mr. Reelle S. Armitage 61 310 West on Ave. Bar. 110</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>160X Cancer of Rt. Anterior -</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Metastasizing to surrounding area -</u>						<u>1 yr -</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Cardio-Vascular Disease</u>						<u>2-3 yrs.</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1958</u> , to <u>5/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/13</u> , 19 <u>55</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Chas. L. Ball Jr.</u>				<u>L. L. Lintich</u>		<u>5/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 17, 1955</u>		<u>First Church of God</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 17, 1955</u>		<u>Clara Thelapp</u>		<u>P. V. Singleton</u>		<u>6122 E. on Ave. Bar. 110</u>	

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4280

CERTIFICATE OF DEATH

04308

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
10. <u>10</u> <u>Annapolis</u> <u>MD</u>		<u>4 days</u>		<u>Edgewater</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>63 Anne Arundel General</u>				<u>1</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)			
<u>THOMAS</u> <u>HEZAKIAH</u>				<u>MAY</u> <u>16</u>		<u>19</u> <u>55</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>C</u>	<u>SINGLE</u>	<u>UNKNOWN</u>	<u>86</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farm hand</u>		<u>Tobacco</u>		<u>Harwood MD</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Thomas</u>				<u>LORACE Giles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>—</u>		<u>—</u>		<u>Randall Thomas Mayo, MD</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <u>Generalized Arteriosclerosis</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>My father's Cardiovascular disease</u>				<u>6 months</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Grade III</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>—</u>		<u>—</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>—</u>		<u>—</u>		<u>—</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>—</u>		<u>—</u>		<u>—</u>			
22. I hereby certify that I attended the deceased from <u>May 10, 1955</u> to <u>May 16, 1955</u> , that I last saw the deceased alive on <u>May 16, 1955</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Dr. Richard E. ...</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>5/16/55</u>	
M.D. <u>110-Clay & ...</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 19/55</u>		<u>Hope Chapel</u>		<u>Edgewater MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>May 19, 1955</u>		<u>—</u>		<u>Bernard Hardisty</u>		<u>Giltsville MD</u>	

WILSON V. S.

1955

1955

4320

CERTIFICATE OF DEATH

Reg. Dist. No. 04309

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Anne Arundel</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Anne Arundel</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Odenton, Md.</i>	LENGTH OF STAY (in this place) <i>30 yr</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Same</i>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>RT 1, box 393</i>		STREET ADDRESS (If rural give location) <i>Same</i>	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>MAMIE</i>	(Middle) <i>ELIZ.</i>	(Last) <i>THOMAS</i>	(Month) <i>May</i> (Day) <i>25</i> (Year) <i>1955</i>
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>col.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Wid.</i>	8. DATE OF BIRTH: <i>Mar. 13, 1885</i>
9. AGE last birthday: <i>70</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Washington, D.C.</i>	
11. BIRTHPLACE (State or foreign country): <i>Yer. USA</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>James HAYES (dec.)</i>		14. MOTHER'S MAIDEN NAME: <i>Mr. Mary Hayer (dec.)</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>no</i>		16. SOCIAL SECURITY No.: <i>none</i>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <i>Sam. Leon H. Thomas - Same address</i>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <i>arteriosclerotic Heart Disease</i>		<i>3 yr</i>
Antecedent causes (s) (b) <i>Hypertension</i>		<i>10 yr</i>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		
(c)		

11. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death. <i>none</i>	
19a. DATE OF OPERATION: <i>none</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg. etc.)	
SUICIDE <i>none</i>		(CITY OR TOWN) (COUNTY) (STATE)	
HOMICIDE			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED	
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from <i>May 25, 1955</i> , to <i>May 25, 1955</i> , that I last saw the deceased			
alive on <i>May 25, 1955</i> , and that death occurred at <i>5-25-55</i> , from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<i>H.F. Manuzak M.D.</i>		<i>5-25-55</i>	
(Degree or title)		ADDRESS	
<i>901 Edgerly Rd, New Burnie, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (Specify)		LOCATION (City, town, or county) (State)	
DATE THEREOF <i>5/26/55</i>		<i>Washington D.C.</i>	
NAME OF CEMETERY OR CREMATORY			
24. FUNERAL DIRECTOR		ADDRESS	
<i>Superior Funeral Home</i>		<i>1432 2nd St. N.W.</i>	

note: This is a patient of Dr. Skerrett for last 3 yrs & I pronounced her dead during his absence from town.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

U.S. AIR FORCE

JUN 2

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

04340

4321

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH— COUNTY <u>Q.A.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <u>Md</u> COUNTY <u>Pr. Geo.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u> <u>Anna</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u> <u>Morningside</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>303 Pine Grove Dr.</u>		STREET ADDRESS (If rural, give location) <u>303 Pine Grove Dr.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>BERNARD</u> (Middle) <u>LYLE</u> (Last) <u>VALENTINE</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>1-6-1928</u>
9. AGE last birthday <u>27</u> yrs.		If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10. USUAL OCCUPATION (Give kind of work done during most of life, even retired) <u>Paroline Station Mgr.</u>		10a. KIND OF BUSINESS OR INDUSTRY <u>Paroline Retail</u>	
11. BIRTHPLACE (State or foreign country) <u>Charlottesville Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard P. Valentine</u>		14. MOTHER'S MAIDEN NAME <u>Mary C. Reynolds</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>yes WW II</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT AND ADDRESS <u>Mr. Jeanne Valentine</u>		(2)	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>129.8</u> <u>Accidental drowning</u>			<u>1/2 hr</u>
(b) Antecedent cause(s) Disease or condition, if any, giving rise to the above cause stating the underlying cause last			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Robertson River</u>	
(CITY OR TOWN) <u>River</u>		(COUNTY) <u>Q.A.</u>	
(STATE) <u>Md.</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5</u> <u>25</u> <u>55</u> <u>7:30 PM</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Accidental drowning (Swimming)</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>D. Borsulich M.D.</u>		DATE SIGNED <u>5/25/55</u>	
23. BURIAL, CREMATION OR REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY <u>Washington National</u>	
DATE THEREOF <u>5-28-1955</u>		LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
DATE REC'D BY LOCAL REG. <u>May 26, 1955</u>		24. FUNERAL DIRECTOR ADDRESS <u>W.W. Chambers Co. Washington, D.C.</u>	

U. S. AIR FORCE

1954

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

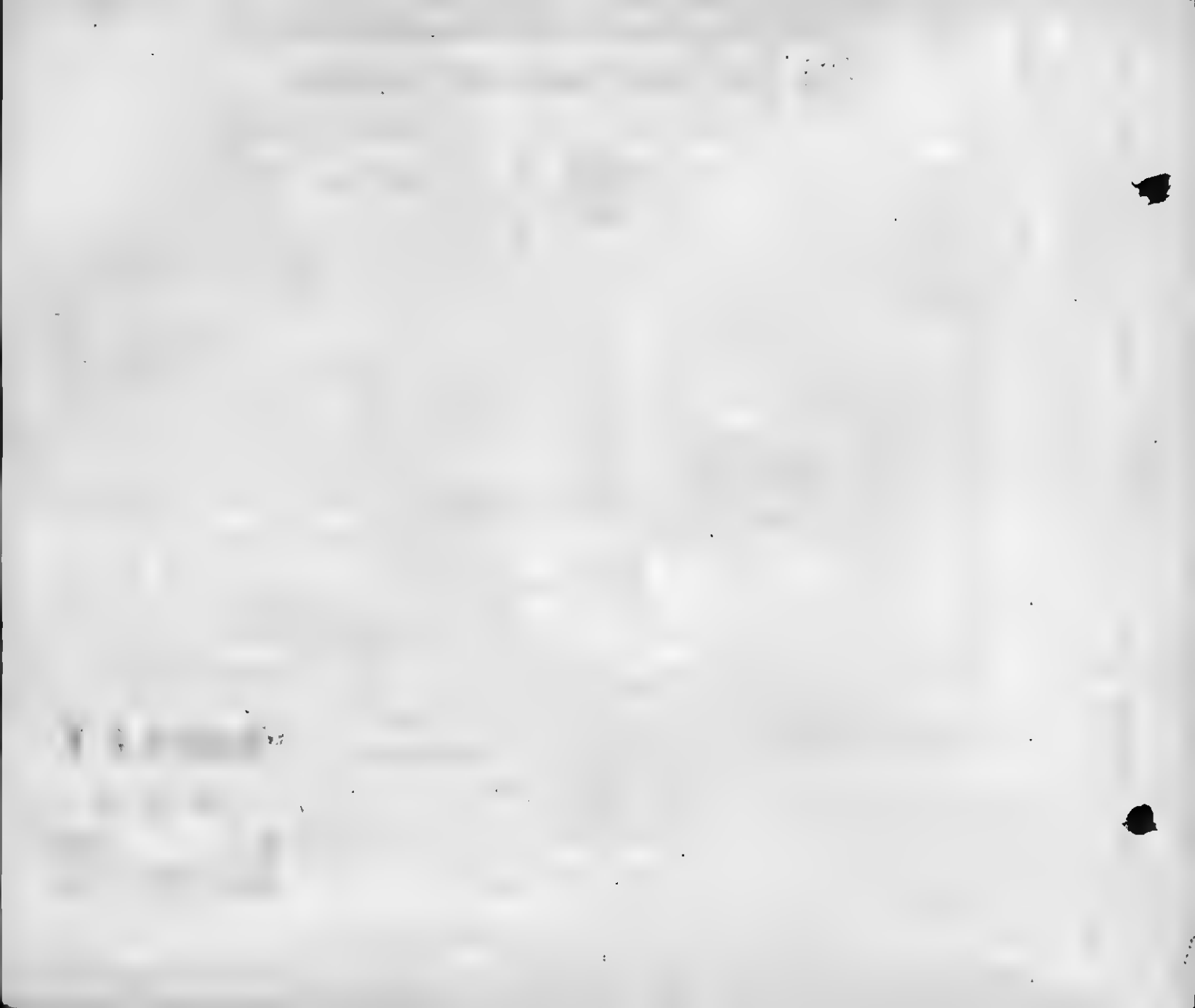
4322

CERTIFICATE OF DEATH

04311

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>MD</u>		COUNTY <u>Anne Arundel</u>	
CITY OR TOWN <u>X Severna Park</u>		LENGTH OF STAY (In this place) <u>45 yrs</u>		CITY OR TOWN <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10</u>				STREET ADDRESS (If rural give location) <u>Cypress Creek Rd!</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>John DANIEL VoGEL SANG</u>				<u>MAY 16 55</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>27 Dec 1889</u>	9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Vogel SANG</u>				14. MOTHER'S MAIDEN NAME <u>CAROLYN. DIMMICK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>7</u>		16. SOCIAL SECURITY NO. <u>720</u>		17. INFORMANT & ADDRESS <u>Mrs. WOLF Severna Park MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>4201 MYOCARDIAL INFARCTION</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>HYPertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1955</u> to <u>MAY 16 1955</u> , that I last saw the deceased alive on <u>APRIL 19 55</u> and that death occurred at <u>ORCA</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Robert B. Hahn</u>		ADDRESS (Street, city, town, state) <u>Severna Park, Md.</u>		DATE SIGNED <u>16 MAY 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/18/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>A.A. Co Md</u>	
24. REC'D BY REGISTRAR <u>May 18, 1955</u>		REGISTRAR'S SIGNATURE <u>Louis J. de Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Luck</u>		ADDRESS <u>5365 Hayford</u>	



4323

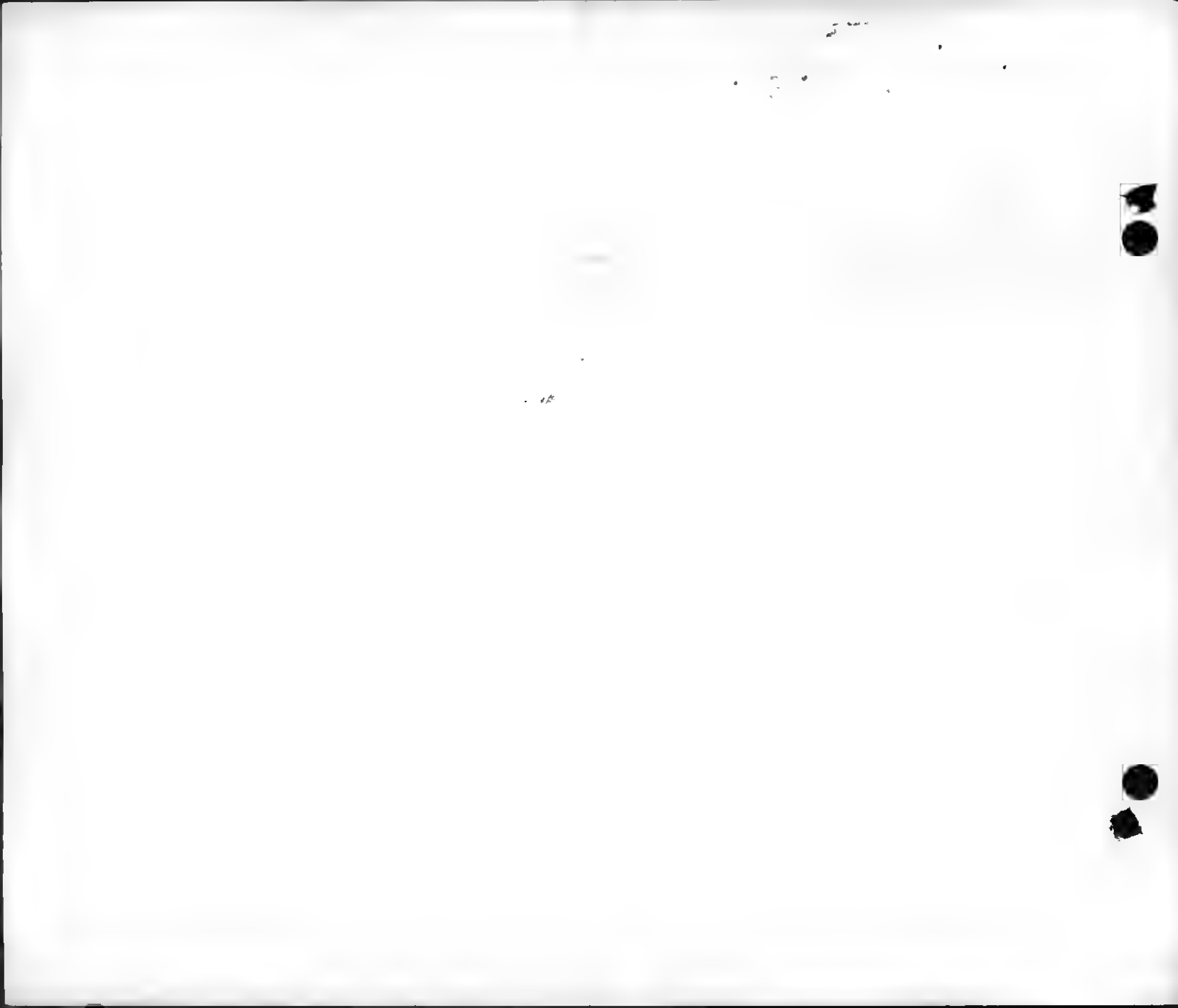
CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL LENGTH OF STREET OR and give nearest town) <u>Brooklyn</u>		(in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>701 Church St.</u>				STREET ADDRESS (If rural give location) <u>701 Church St.</u>			
3. NAME OF DECEASED: (First) <u>FRANK</u> (Middle) <u>F. Von</u> (Last) <u>Colin</u>				4. DATE OF DEATH: (Month) <u>5</u> (Day) <u>3</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>		8. DATE OF BIRTH: <u>5-4-05</u>	
				9. AGE last birthday: <u>49</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life even if retired: <u>FIRE WORKER</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>U.S. I.A.</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore</u>	
13. FATHER'S NAME: <u>Howard</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Schuch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>				16. SOCIAL SECURITY No.: <u></u>		17. INFORMANT & ADDRESS: <u>Family - Same</u>	
18. MEDICAL CERTIFICATION				Interval Between Onset And Death			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>420.1</u> <u>CORONARY THROMBOSIS</u>				<u>2 hrs.</u>			
Antecedent causes (s) (b) <u>Arteriosclerosis C.V. disease</u>				<u>?</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u></u>							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		HOMICIDE					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>54</u> , to <u>May 3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 3</u> , 19 <u>55</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.				DATE SIGNED			
SIGNATURE <u>John R. Schuch</u>		(Degree or title) <u>MD.</u>		ADDRESS <u>4701 Pennington Ave.</u>		<u>5/3/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>5-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedarvale</u>		LOCATION (city, town, or county) (State) <u>Baltimore</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-5-55</u>		REGISTRAR'S SIGNATURE <u>aw Redmond</u>		24. FUNERAL DIRECTOR <u>J. L. McCarney</u>		ADDRESS <u>1308 Fort Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certifying age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A5C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04313

4324 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		STATE Maryland		COUNTY Baltimore City			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Crownsville		21 yrs. 2 mos.		TOWN Baltimore City		3 Vol. 4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital				STREET ADDRESS (If rural give location) Hanover & York Streets			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Walter (Middle) Wallace (Last)				(Month) 5 (Day) 14 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Negro	Married	Unknown	67? yrs.	Months 5 Days 14	Hours 19 Min 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Furrier		Fur		Maryland		U. S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Samuel Wallace				Anna May Booth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Unk.		Unk.		Hospital Records			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) General Paresis				INTERVAL BETWEEN ONSET AND DEATH Known to us since 2/28/34			
ANTECEDENT CAUSE(S) (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
025X				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/21 , 19 48 , to 5/14 , 19 55 , that I last saw the deceased alive on 5/14 , 19 55 , and that death occurred at 10 P.M. from the causes and on the date stated above.							
SIGNATURE		(L. Benedict, M. D.)		ADDRESS (Street, city, town, state)		DATE SIGNED	
May 19 '55		M. D.		Crownsville, Md.		5/15/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
5/23/55		Brown's Chapel		Calvert Co. Port Republic			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
May 19 '55		R. M. Joyce		P. E. Sewell Prince Frederick, Md.			

BRAND A. B.

NY 1955

VED

MARYLAND

04314
STATE DEPARTMENT OF HEALTH

4325

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PASADENA</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PASADENA MD.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Light & Mission St.</u>		STREET ADDRESS (If rural, give location) <u>Light & Mission Sts.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Christine</u> <u>Walter</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 25</u> 19 <u>55</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>WIDOWED</u>	8. DATE OF BIRTH <u>March 26-1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>78</u> yta. If under 1 year 1 year 11 months 10 days 11 hours 11 min.
13. FATHER'S NAME <u>Augustus Appelstiel</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON DC.</u>	
14. MOTHER'S MAIDEN NAME <u>Sofia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>812-24-8730</u>	
17. INFORMANT AND ADDRESS <u>Daughter - Mrs Irma S. Bussey</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Respiratory & Circulatory Failure</u> <u>myocardial Infarction</u> <u>Arteriosclerotic Cardio Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9 May</u> , 19 <u>55</u> , to <u>25 MAY</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>24 May</u> , 19 <u>55</u> , and that death occurred at <u>6745A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Robert R. Halim</u>		ADDRESS <u>Severna Park Md</u> DATE SIGNED <u>25 May 55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE <u>5/28/55</u> NAME OF CEMETERY OR CREMATORY <u>London Park</u> LOCATION (City, town, or county) (State) <u>MD</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>5-26-55</u>		24. FUNERAL DIRECTOR <u>Edward J. Luck</u> ADDRESS <u>530 W. Bayford</u>	

MARGIN RESERVED FOR BINDING

1955
78
1877



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04315

4326

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Gambrills</u>		<u>7 years</u>		TOWN <u>Gambrills</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S.N.A. dairy Farm</u>				STREET ADDRESS (If rural give location) <u>U.S.N.A. Dairy Farm.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Sarah</u> (Middle) <u>Ann</u> (Last) <u>Waters</u>				(Month) <u>May</u> (Day) <u>28</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>June 13 1874</u>	<u>80</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>House work (Retired)</u>		<u>Own Home</u>		<u>Anne Arundel Co., Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>James R. Warfield</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. John Hutchins, Gambrills, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>2 days</u>	
44-X IMMEDIATE CAUSE (A) <u>Cerebral Accident</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardio-Vascular Disease</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>5</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 47</u> , 19 <u>47</u> , to <u>May 28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 27</u> , 19 <u>55</u> , and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Edward G. Sherritt</u>				ADDRESS (Street, city, town, state) <u>Gambrills Md</u>		DATE SIGNED <u>5-28-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 31, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial Cemetery</u>		LOCATION (City, town, or county) <u>Savern Cross Roads Md.</u>	
24. REC'D BY REGISTRAR <u>May 31, 1955</u>		REGISTRAR'S SIGNATURE <u>Katherine M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Kingston</u>		ADDRESS <u>Glen Burnie, Md.</u>	

THE A. C. C. C.

04316

MARYLAND STATE DEPARTMENT OF HEALTH

4327

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 10

1. PLACE OF DEATH - COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>md.</u> COUNTY <u>aa.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Brooklyn</u> LENGTH OF STAY (in this place) <u>12 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Brooklyn</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>237 - Edgewood Rd.</u>		STREET ADDRESS (If rural, give location) <u>237 Edgewood Rd.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>MILTON - RAYMONS - WAXTER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May 27 1950</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>6/19/88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	9. AGE last birthday <u>66</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Saltzman, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Waxter</u>		14. MOTHER'S MAIDEN NAME <u>Mary Florence Stevens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Navy 1914</u>		16. SOCIAL SECURITY NO. <u>215-07-7140</u>	
17. INFORMANT AND ADDRESS <u>Mrs. F. Waxter (wife)</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a) Coronary Occlusion

INTERVAL BETWEEN ONSET AND DEATH

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m. INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☒22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☒ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. RIAL CREMATION (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

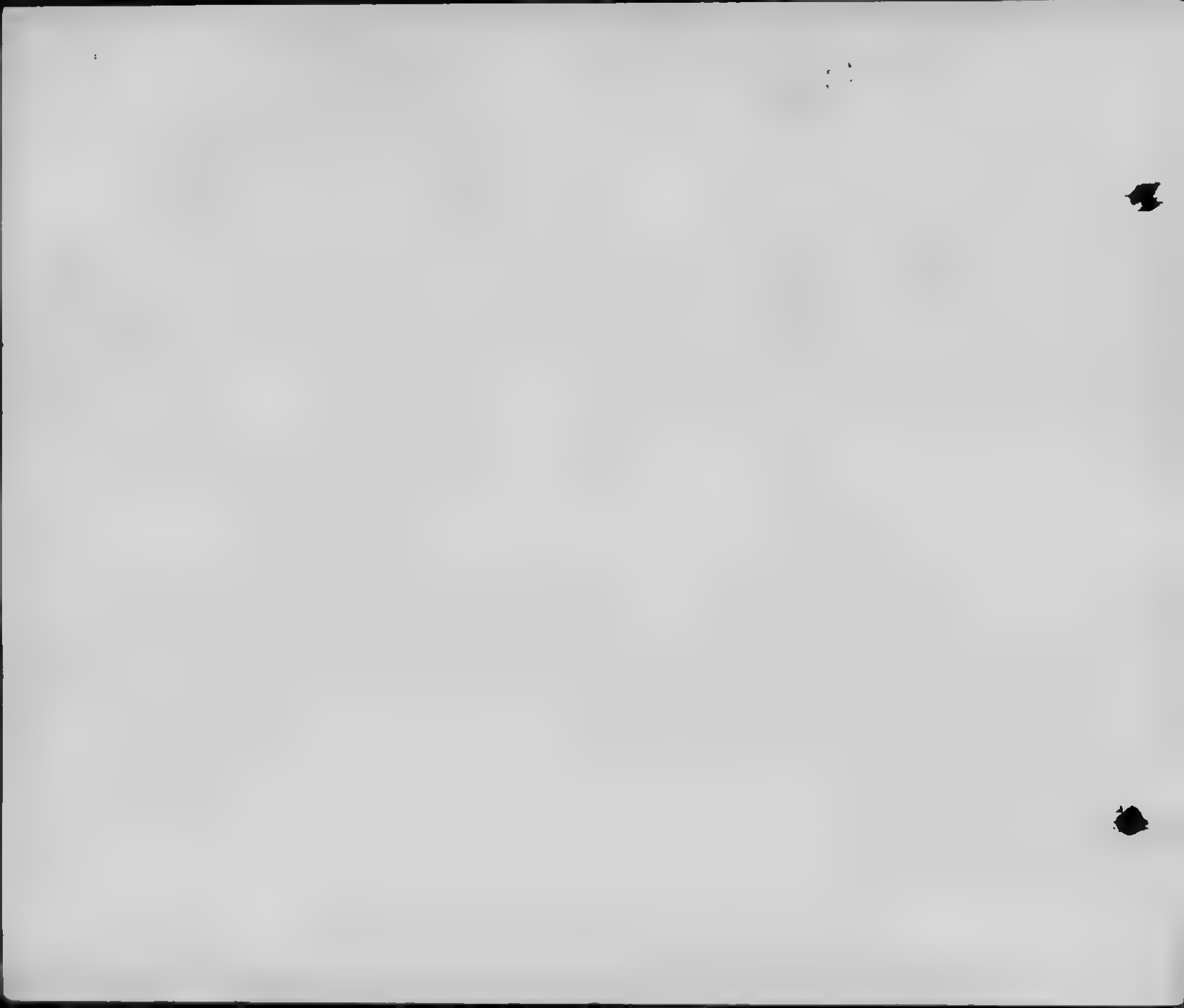
REGISTRAR'S SIGNATURE

M. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

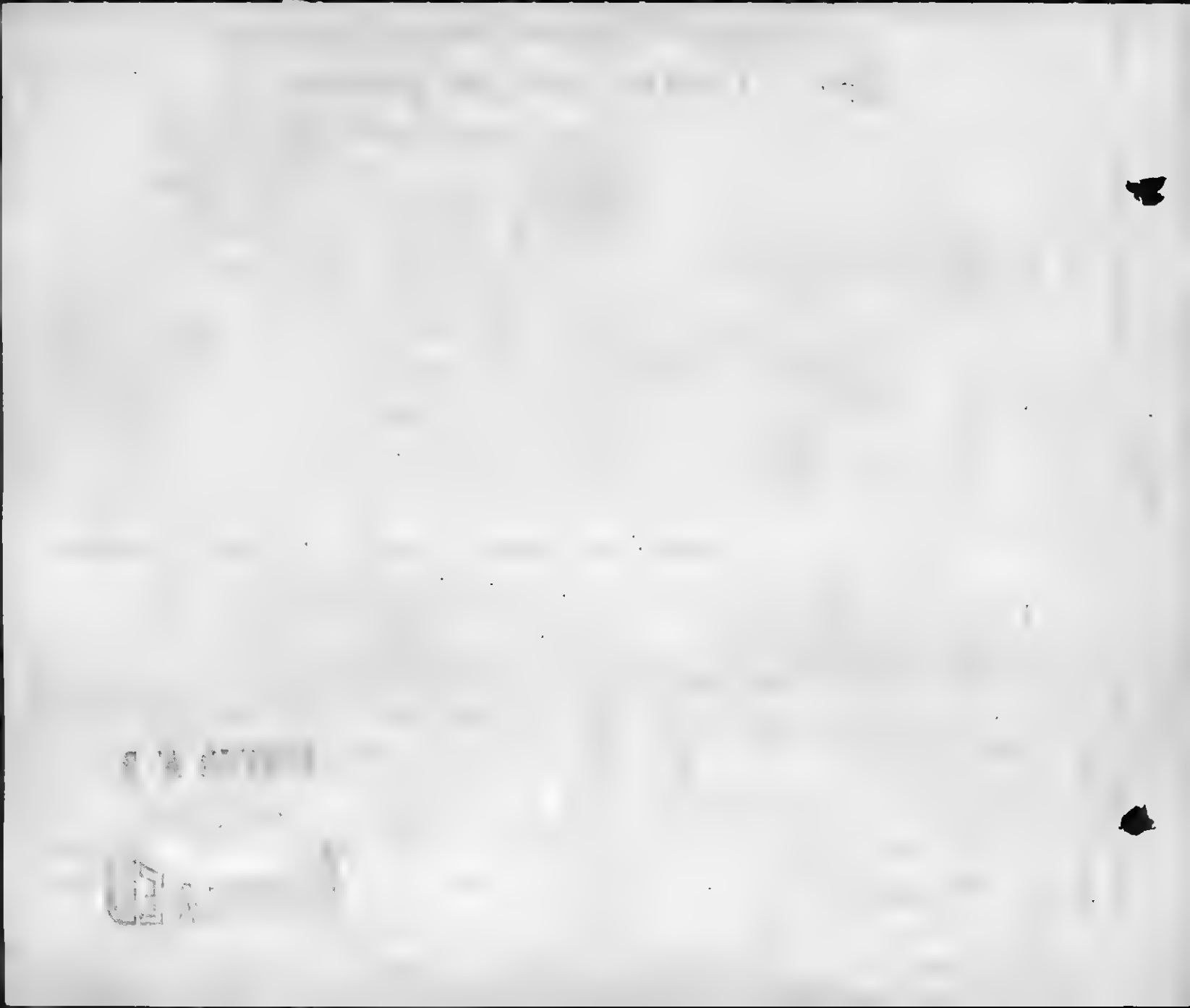
4328

CERTIFICATE OF DEATH

04317

Reg. Dist. No. 22

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE-ARUNDEL</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>ANNE-ARUNDEL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SEVERN-RFD</u>		<u>54 years</u>		TOWN <u>SEVERN-RFD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>New-Cut-Road</u>				<u>New-Cut-Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>William</u> (Middle) <u>W.</u> (Last) <u>Wheeler</u>				(Month) <u>May</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Sept. 30-1870</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>FARMER</u>		<u>Retired (Farm)</u>		<u>Anne Arundel Co., Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William W. Wheeler</u>				<u>Liza-Stinchcomb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NONE</u>		<u>Clinton Wheeler-Severn-RFD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)		<u>Arterio-sclerotic Heart Disease</u>				<u>2 Years</u>	
ANTECEDENT CAUSE(S) DUE TO (B)		<u>Generalized Arterio sclerosis</u>				<u>11 Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>2 Years</u>	
<u>Peripheral Vascular Disease</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov</u> , 19 <u>46</u> , to <u>May 25</u> , 19 <u>55</u> that I last saw the deceased alive on <u>May 24</u> , 19 <u>55</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Edward G. Bennett</u>				<u>Edmondville Md</u>		<u>5-26-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 28-1955</u>		<u>Glen Haven</u>		<u>Glen Burnie-Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>May 31, 1955</u>		<u>Clara Horsley</u>		<u>E.R. Singleton</u>		<u>Glen Burnie, Md.</u>	
		<u>L.J. Daalva</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04318

4329

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH- COUNTY <u>A. A. Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>A.A.Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lanham, R.D.</u> LENGTH OF STAY (in this place) <u>25 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lanham Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lanham-Annapolis Jct. Rd.</u>		STREET ADDRESS (If rural, give location) <u>Lanham-Annapolis Jct. Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>Richard A. Whitehead</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>11</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>March 16, 1889</u> 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O R.R. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Whitehead</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>David Whitehead, Lanham, Md</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Peritonitis</u>		<u>48 hrs.</u>	
(b) Antecedent cause(s) <u>Gastric Ulcer</u>		<u>5 yrs.</u>	
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>U. B. - Pt. refused hospitalization.</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 8th</u> , 19 <u>55</u> , to <u>May 11th</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>May 11th</u> , 19 <u>55</u> , and that death occurred at <u>5:30 P.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Frank Shipley, M.D.</u>		DATE SIGNED <u>5/12/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 14, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (city, town, or county) (State) <u>Lanham, Maryland</u>	
24. FUNERAL DIRECTOR <u>Charles R. Raskin</u>		ADDRESS <u>2411 N. Charles St. Baltimore, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BOHEAN V. S.

JUN 2 19

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 18 Film G182 6-17-55 ams

04319

4330

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Ft GG Meade, Md.</u>		<u>unknown</u>		OR TOWN <u>Baltimore</u>		<u>3701-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>		STREET ADDRESS (If rural give location)		<u>1500 Eutaw Place</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Jack E. Williamson</u>				<u>May 27 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>single</u>	<u>25 November 1933</u>	<u>21</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Soldier</u>		<u>U.S. Army</u>		<u>West Virginia</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Bannon Williamson</u>				<u>Mabel Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>5 Oct 53 to death</u>		<u>unknown</u>		<u>Army Service Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
784.1 IMMEDIATE CAUSE (A) <u>Aspiration of gastric contents.</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Vomiting of undetermined origin. (not accidental)</u>						<u>DOA</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>2</u>				<u>YES</u> <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>DOA</u>, 19....., to <u>DOA</u>, 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>approx 0910</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James M. Foley</u>				ADDRESS (Street, city, town, state)			
<u>JAMES M. FOLEY, LT. COL. MC</u>				<u>Ft GG Meade, Maryland</u>			
DATE <u>27 May 55</u>				DATE SIGNED <u>27 May 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)			
<u>Burial</u>		<u>Buskark Cemetary</u>		<u>Matowan, Ky.</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>WILLIAM L. SAYLOR, 1/Lt MSC</u>		<u>WILLIAM COOK</u>		<u>Baltimore, Maryland</u>			

CERTIFICATE OF DEATH

1955

1955

BUREAU V. S.

JUN 1 1955

RECEIVED

4281

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY <u>Q. Q.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Q. Q.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>C. G. General Hosp.</u>		STREET ADDRESS (If rural, give location) <u>304 Washington St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u> (Middle) <u>L.</u> (Last) <u>Windsor Jr.</u>	4. DATE OF DEATH (Month) <u>5</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>2-2-1935</u>
9. AGE last birthday <u>20</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>Cambridge Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>James L. Windsor Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Monobray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Katherine M. Windsor</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

976X

Immediate cause

Gun Shot Wound - Skull

INTERVAL BETWEEN ONSET AND DEATH

Instant

Antecedent cause(s)

Disease or condition, if any, giving rise to the above cause stating the underlying cause last

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>HOME</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>May 15 5:55 A. M.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Self Inflicted</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died as the dry stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL OR CREMATION (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>5-17-55</u>	<u>Hill Crest Memorial</u>	<u>Annapolis</u>	<u>Md.</u>
DATE REC'D BY LOCAL REG.	REGISTER'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS		
<u>May 16, 1955</u>	<u>J. J. Trench</u>	<u>John M. Taylor Sons Annapolis Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 18 1955

RECEIVED

BUR